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CLEANING UP: THE SOCIAL ORGANIZATION OF WOMEN AND DRUG USE

by

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Abstract

Using Dorothy Smith's institutional ethnography as a method of inquiry, this research focuses on the social organization of women's drug use. Interviews with women, agency professionals and documents were analyzed to show how the lives of women who use alcohol and drugs were ordered and coordinated. Using the analytical tool, social relations, I examined concepts as practices. Concepts determine and are determined by "in common" understanding and shape how women and drug use is understood by both women and professionals. I present three arguments; that women do "medical work," "social skills work," and "moral work" when they talk about drug-using experiences, that women's actual experience is marginalized in the institutional account, and that conceptual practices preserve inequities in relationships of power between women and institutions.

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Acknowledgments

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Cleaning Up: The Social Organization of Women and Drug Use

CHAPTER ONE: WOMEN AND DRUG USE

Introduction

I first became curious about women and drug use when I applied for a position as a counsellor in an alcohol and drug residential treatment centre ten years ago. During the job interview, I was asked the question, "Do you think there is a difference between men and women and their chemical dependency?" At the time, I responded that I thought there was but because I had very little clinical or experiential information on which to base that opinion, I could not articulate those differences. As I began to work in the alcohol and drug field, and particularly with women who had problems with drug use, I read about these differences, heard about these differences from the women I worked with, and became interested in how this information could be used to develop and implement gender-specific programs.

As I continued to learn more about women and drug use, there were times I could identify "automatic" responses given by women attending agency programs. For example, when a woman is asked why she came into a residential treatment program, she may explain that her children have been removed and she will lose them permanently if she does not complete a residential treatment program. "But," she will add, "I'm here for me." This reply has happened so frequently that I became intrigued by what I call "coached correct answers." Where did these women from various Northern British Columbia communities and with various experiences and backgrounds, learn to say this? How has "I'm here for me" been given such meaningful status that it becomes a common phrase and even a "correct answer" in this context? I became interested in examining not only what professionals know, but also how professionals and women themselves know about women and drug use.

I began my search with what is most immediate to me. I looked at my childhood for stories of women and drug use. In my family, these stories were untold or at least closely guarded family secrets. The behaviour of women using drugs in my family was almost invisible to outsiders. In my teens, I was told of a few scattered incidents. For instance, I was told that my grandmother was an alcoholic. This conversation happened in hushed tones in the background of a family get-together. At that time, women's drinking was considered rare and unusual. Some women who drank alcohol, no matter how heavily, were labelled "alcoholics." I did not hear these family stories about drinking and drug use from the women involved, but from other relatives. These women were silenced under the guise of protecting them and their families from intrusion or embarrassment, so I do not know if the stories are true, nor do I understand what they experienced. I notice even now, thirty years later, the pressure to remain silent about these stories of women and drug use.

When I examined the research literature on alcohol and drug use, I found most early studies (1960s) were conducted on men by male researchers. Where women were included, there was no gender differentiation in the analysis of the findings. There was little information specific to women in those early studies. When women were named as the subjects of the research in the early seventies, much of the information centred on biological differences in physiological response to alcohol and drug use, particularly in the reproductive system. As feminism began to influence research of the eighties, the social context of women and drug use was studied. In the nineties, qualitative research provided an understanding of the lives of women through rich descriptions of their experiences. While research has added to our awareness of women and drug use, it does not explain how women come to describe their experiences in the way that they do. How do they come to have an "in common" understanding

about what drug use is? How is it that they talk about their drug use and help seeking in similar ways?

My inquiry began in the actual lived experience of women and drug use and in the talk about it: women's own language and professional language. While "drug use" and "drug misuse" are different conceptually, on an experiential level, drug use and misuse exist on a continuum of use. I was curious about how "drug use" becomes "drug misuse." I wanted to know who makes this decision and what criteria are used. The practice of naming in the alcohol and drug field has given rise to a number of terms like chemical dependency, addiction, alcoholism, substance abuse and misuse. Drug misuse is the professional term currently accepted in British Columbia by Addiction Services[1]. In this thesis, I made a distinction between drug use and drug misuse: the term "drug misuse" refers to professional terminology describing problem drug use, otherwise, the more commonplace phrase, "drug use" is used. Rinaldi et al. (1988) describe the history of confusion regarding a non-standard lexicon related to the use of psychoactive[2] drugs over a variety of professional disciplines. They use a Delphi survey method to reach some consensus among professionals to standardize terminology. I use their definition of drug misuse: "any use of a drug that varies from a socially or medically accepted use" (p. 557). The term "drug misuse" includes alcohol and other drugs, both licit and illicit. It also includes misuse of prescription drugs, but not misuse of tobacco or caffeine.

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[1]Addiction Services is the provincial organization in British Columbia that employs alcohol and drug professionals who coordinate assessment, education, treatment and prevention opportunities for those whose lives are affected by drug use and problem gambling. This institution was formerly known as Alcohol and Drug Programs.

[2]Barker (1999) defines psychoactive drugs as "drugs that induce changes in the user's mood, cognitive ability, or perceptions" (p. 385).

Where there are distinctions, or where I refer to a particular drug, the drug or drug category is identified specifically. As I began my research, I wondered if there were differences between how drug misuse is known professionally and how the use of drugs is known experientially in the lives of women.

While it may appear on the surface to be a simple decision for women to stop using drugs, there are often many ideas, practices, and policies that shape how this is individually determined. There are times when women are told that they have a problem with drug misuse by professionals in specific institutions, particularly those with a legislated mandate, as happens in the case of child protection issues or impaired driving charges. I became interested in how professionals make decisions about women and drug misuse.

Many women do not seek help from professionals when they have problems with drug use, and Roberts and Ogborne (1999) state, "...using broad definitions [of "help" and "problems"] it appears that in North America most people who experience problems associated with their use of alcohol or other drugs do not intentionally seek help for drinking or drug use from either general or specialized services" (p. 54). Women who decide they have a problem with drugs may then choose to do something about it. Roberts and Ogborne (1999) report that, "Weisner, Greenfield and Room (1995) found that women with drinking problems in the general population, unlike men, reported more use of health and mental health programs than alcohol treatment programs" (p. 54). In this way, problem identification becomes the initial step in the work of change, or, "recovery." I used the term recovery, "a process of overcoming both physiological and psychological dependence on a drug or alcohol" (Rinaldi et al., 1988, p. 557), in the broadest sense of the word. Recovery may include the goal of abstinence but also includes

any goals that reduce harm in the use of drugs. Women may seek professional help to recover when they recognize they have a problem with drug use.

This work that women do in identifying drug use as a problem sometimes involves other agencies and their conceptualization of what constitutes a drug problem. I have taken the view that to understand the many puzzles about women's drug use and misuse, I need to understand how drug use is described by the women themselves and how women's drug use is understood in the documentation and practices of professional agencies that impact their lives.

To explore how women and drug use is understood, I chose for my title the everyday euphemism, "cleaning up," that one of the women I interviewed used. This double entendre refers to the stereotypical role of women being responsible for cleaning in our society and refers to quitting drugs. The women I interviewed had already identified alcohol and/or drug use as a problem in their lives. I explored how they knew from their own experience that drugs were a problem in their lives and how they came to describe their experience in particular ways. The following section examines the literature to discover how women and drug use is understood.

Literature Review

In order to become familiar with current knowledge, I began my inquiry by looking at the research literature about alcohol and drugs. Research on men by male researchers dominates the field, and only a few studies specific to women and drug misuse were published prior to 1970 (Harrison & Belille, 1987, p. 574; Wilsnack, Wilsnack, & Hiller-Sturmhofel, 1994, p. 173).

Women Subsumed under Men's Experience

In the 1970s, when it first became recognized that women also experience drug problems, the same treatment[3] theories were applied to them. Current studies indicate this trend. Saunders et al. (1993) examined the predominance of males within treatment agencies and explained, "Given this ratio of male to female clients it is hardly surprising that the alcohol treatment industry has been geared to the treatment of male clients" (p. 1413). But as Millstein (1998) argues, "Research that has a male-only approach cannot continue. And it cannot be assumed that the results from research based exclusively on male subjects can be extrapolated confidently and generalized safely to females" (p. 573). Unstudied, women's experience with drugs was assumed to mirror men's experience.

Biological Approach to Women and Drug Use

Subsequently, physiological differences between men and women became the focus as women became subjects of predominantly quantitative research designs of the early eighties. For example, because women have a higher ratio of body fat to muscle tissue than men, they are more likely to become intoxicated quicker (Pape, 1993, p. 251). Women's bodies respond to alcohol variably throughout the menstrual cycle, and they are more likely to become intoxicated faster just prior to menstruation than at other times in their menstrual cycle (Pape, 1993). This means that the effects of alcohol on women are more unpredictable and the same level of use would produce different results for the same woman at different times in her monthly cycle.

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[3]Alcohol and Drug Programs (1987) defines treatment as "the broad range of planned and continuing activities designed to alleviate substance misuse problems" (glossary).

Even though women usually have a later onset of problem drinking than men (Blume, 1986; Wilke, 1994), the rapid medical complications that women experience, although they have a shorter history of alcohol use than men, is called telescoped progression. Therefore, women may benefit most from early intervention before significant damage has taken place. Notably, sexual dysfunction may be a precursor to alcohol misuse and may be a contributing factor in alcoholism (Wilsnack, 1984, p. 199). Gomberg (1994) suggests that there is a significant link between reproductive dysfunction and drinking, although findings do not indicate which came first. Blume (1986) cited in Kinney (1991) found that depression, suicide attempts and other affective disorders are more common in women than men. Gomberg (1994) also found a link between depression and problem drinking at all stages in a woman's lifespan (p. 221).

Furthermore, women are more likely to use psychoactive drugs and are more likely to be polydrug users than men (Celentano & McQueen, 1984). Doctors are more likely to prescribe mood-modifying drugs to women than men, and women are more likely to misuse prescription drugs than men ((Marsh & Miller, 1985) cited in (Kinney, 1991, p. 224)). Johnson (1987) states, "The prevalence of illicit drug use is higher among men than women, but new drug use occurs at twice the rate for females as for males" (p. 42). While drug use has biological implications for women, this early research left gaps in describing women's experience with drug use. Consequently, I examined the significance of social context as revealed by the researchers I've referenced below.

Social Context As a Factor

Hughes (1990) explains, "Women's health in the 1980s, ...began to concern itself with the overall experience of women, their position in society and the communities in which they live,

not just diseases or childbearing functions" (p. 36). Research about women and drug misuse shifted from the biological effects on women and their reproductive role and moved toward a more holistic approach. At this time, the social context in which women live was given consideration. For example, according to Kinney (1991), women are more likely to drink alone and drink at home. She also states women are "still more likely to hide their drinking" (p. 227). Social isolation and women's problem drinking is also identified by Gomberg & Lisansky (1984, p. 251). Davis & DiNitto (1996) found that alcoholic women were more likely than their male counterparts to experience family and social difficulties and that they were more likely to have "familial alcoholism" (p. 142).

In addition, women are also more likely than men to remain with their alcohol using partners while men are more likely to leave ((Gomberg, 1991) cited in (Finkelstein, Kennedy, Thomas, & Kearns, 1997 p. 13)). According to the National Institute on Drug Abuse (1999):

> Many women report that their drug-using male sex partners initiated them into drug abuse. In addition, research indicates that drug-dependent women have great difficulty abstaining from drugs, when the lifestyle of their male partner is one that supports drug use (p. 1).

The findings of Kauffman, Silver, & Poulin (1997) indicate women believe relationship problems and stress are contributing factors in their substance abuse. However, Hughes (1990) challenges the interpretation that women use drugs and drink more often than men due to stress, as this "implies that women's emotional stability is more easily disrupted than men's" and cautions against 'male-as-norm' bias in analysis (p. 41). In examining effective treatment approaches for women with chemical dependency problems, Hughes (1990) asserts "women tend to experience greater shame and guilt associated with chemical dependency and therefore often respond better to supportive rather than strictly confrontive strategies" (p. 44). Women who seek help for drug use often view themselves in negative terms and feel stigmatized by

others. Derogatory ideas about women and drug use are pervasive and well documented (Addiction Research Foundation, 1996; Wilsnack & Beckman, 1984). Drabble (1996) explains that women who misuse drugs are frequently dealing with issues of violence and abuse both in the present and in childhood and are dealing with attendant feelings of low self-esteem and shame.

Recently, the National Institute of Drug Abuse (NIDA) found, "NIDA has a long history of studying women and sex differences; however, most of these studies have been among pregnant women and their offspring. Now it is necessary to look at females as independent individuals, not just in their role as mothers" (Millstein, 1998, p. 573). This is important because traditional research focuses primarily on the biological/physiological aspect of women and their reproductive role in society. This limits our understanding of women and fails to examine critical elements like social context and the implications of class, discrimination, racism, and oppression in women's lives. Across women's lifespans, their reproductive years are limited, and with more women choosing not to bear children, many women are excluded from study and their experience marginalized. Wallen (1998) notes that, "In addition to the scarcity of information about services provided to women in drug abuse treatment, relatively little is known about the characteristics and treatment needs of women in drug abuse treatment" (p. 230). Furthermore, she argues, "Research is needed to examine how women in treatment came to be there, identify differences among subpopulations of women in the route by which they entered treatment, and compare women with drug problems who are in treatment with women who have drug problems in the general population" (p. 232). While the above quantitative studies are helpful because they recognize the distinction between men's and women's drug use,

they do not tell me how women talk about their experiences with drug use. For this reason, I turned to qualitative studies.

Challenging Stereotypes: Women's Experience Revealed by Qualitative Research

Qualitative research offers new insights into the lives of women who use drugs. For example, Sterk-Elifson (1996), in examining cocaine use among middle-class women, stresses that class, racism, privilege, discrimination and gender issues are part of the complexities of drug use that are not visible when looking at epidemiological findings alone. The women in her study challenged the current stereotype of drug users as ethnic minorities and as poor. In addition, Erickson & Murray (1989) argue that:

> After reviewing the scientific literature and analyzing the results of an original research study, this paper argues that there is no evidence that women's cocaine use exceeds that of men's, that women's rates of use are growing faster than men's, or that female cocaine users experience more problems than that of male cocaine users. Since the deviant image of the female cocaine user is a social construction lacking a factual basis, we conclude that a different standard is being applied to women who use cocaine than to men who use cocaine (p. 135).

Erickson and Murray go on to illustrate how drug-using women experience more social stigma than men and to have been more likely characterized as sexually deviant or promiscuous than their male counterparts.

Furthermore, Friedman & Alicea (1995) posit that "traditional drug abuse research imposes a deviance model on substance users and thereby perpetuates their stigmatization" (p. 432). When they studied women and heroin, they found drug use was a political act in response to cultural expectations for women. Their study focused on white middle and upper class females and their findings indicate that resistance to social pressure led many of these women

into heroin use. This also challenges the stereotype of the economically oppressed heroin addict, and proposes a new rationale for drug use by women.

Another study examines the role of mothering and drug use. Again, Baker & Carson (1999) question the stereotype that women who use drugs are always bad parents and offer women's stories of their experience to illustrate their parenting practices. While these women admitted to falling short in some areas, they were able to identify ways in which they were capable, loving caregivers, such as reading bedtime stories, providing food, shelter and clothing, and ensuring that their children were always tended and their children were protected from harm. By studying the experience of women who use drugs, qualitative research supports richer narratives that challenge assumptions about these women. Again, while this body of literature was informative and alerted me to themes which might arise in my interviews, my questions about how women come to describe their drug use the way they do remained unanswered. The following section briefly describes the traditional theories of drug misuse that have been professionally developed in the alcohol and drug field to explain the nature of drug misuse.

Traditional Theories

As part of my review, I thought it important to understand various theories of addiction because ideas about drug use have changed over time. This historical perspective provides another context in which women come to understand their drug use. Once again, most of the theoretical models about drug misuse are based on research by male researchers and male social scientists using males as subjects with very little attention paid to women who experienced problems with drugs (Wilsnack et al., 1994; Wilsnack & Beckman, 1984). While these theories are outlined as separate models in the following review, there is considerable overlap in both

content and timespan. Theory names are consistent with those outlined in policy by Addiction Services, issued in January, 1996 (Alcohol and Drug Programs, 1987, updated).

Moral Theory

According to this theory, people who misused alcohol were viewed as sinful, immoral, evil or depraved. This notion has been prevalent since the 1800s. Lender & Martin (1987) state "If people denounced cases of individual intemperance, they did not directly intimate that the fault lay in the liquor itself; the problem was one of isolated deviants misusing what society viewed as a wholesome, healthful and even necessary product" (p. 21). Alcohol misuse was understood as a personal problem. Rose (1996) and Lender & Martin (1987) illustrate that women were active in the early Temperance Movement that encouraged prohibition and also in the drive to repeal prohibition, because they were seen as the moral authority in the home. Rose also states that women who drank were "warned of consequences such as illness, loss of reputation, suicidal passion or an eternity in hell" and could "transform their lives by embracing the values and morals that temperance women themselves personified" (p. 14).

Moral Theory proposes that treatment would consist of repentance of sins and choosing not to drink or use drugs based on moral grounds. Lender (1986) describes the stigma that women faced:

> Women were virtuous and pure, alcoholics were degraded; women defended the home, alcoholics imperiled it; and while mothers strove to raise their children in a moral environment, drunkards were constant impediments to the task. Thus, to be an alcoholic was to behave in a way that was so removed from public expectations of women in the nineteenth century that society could account for it only as a form of the most extreme deviance (p. 47).

This highly moralistic approach is still prevalent in society. While currently denounced as a credible approach in working with alcohol and drug misuse, nonetheless, professionals often

hear these notions of women who use drugs and alcohol, which are reflected in judgmental attitudes toward women and mothers in particular, and women themselves organize their thinking in the same way (Addiction Research Foundation, 1996, p. 31-2).

Spiritual Theory

This theory, formulated in the late 1930s, is based on the notion that alcohol and drug misuse results from loss of spiritual direction. Admitting powerlessness over alcohol and then turning one's life over to a Higher Power paraphrase two of the Twelve Steps of the Alcoholics Anonymous program (Addiction Research Foundation, 1996, p. 79). The "Big Book" (Alcoholics Anonymous, 1939) describes in story form how men have recovered through total abstinence, regularly attending Alcoholics Anonymous meetings based on a self-help model, acceptance of some form of spiritual belief system or faith in a power greater than oneself, and making amends for personal wrongdoings where possible.

Alcoholics Anonymous was created by men, primarily for men who drink. Although women are encouraged to follow the model developed, there is little attention paid to gender difference in substance misuse (Alcoholics Anonymous, 1939, p. 104). Alcoholics Anonymous is still widely used as a mode of treatment for both men and women. Some specific Alcoholics Anonymous groups have been designated for women only without changing the major premises. Professionals often refer women to self-help groups like Alcoholics Anonymous for peer support to augment agency services they provide.

Disease Theory

This theory argues for the biological effects of the ingestion of specific chemicals on the body and the resultant behavior as chemical reaction symptoms. It also believes that biological determinants may contribute to a predisposition for addiction and emphasizes the role of genetics. The modern concept of alcoholism as a disease was developed by Jellinek (1960). Described in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1987, third edition, revised), alcohol dependence, alcohol abuse and alcohol withdrawal are viewed as clinical diagnoses. This manual states:

> Females with Alcohol Dependence have been studied less extensively than males, but the evidence suggests that the course of the disorder is more variable in females. The onset often occurs later, and spontaneous remission is apparently less frequent. Females with alcoholism are also more likely to have a history of a Mood Disorder (p. 174).

As suggested, this clinical diagnosis determines specific treatment implications for women who decide to quit using alcohol.

This theory states that despite any other intervention, the only way to stop the progression of the disease and to recover from the effects of alcoholism is abstinence. Implications are that "users are often 'in denial'[4] and not ready to address their substance use problem or make a change until they 'hit bottom'" (Addiction Research Foundation, 1996, p. 34). In describing the medical management of the disease of alcoholism, Kissin (1977a) recommends drug therapy--Disulfiram (Antabuse) to discourage impulsive use and possibly Chlordiazepoxide for treatment of withdrawal symptoms and anxiety--as well as psychotherapy and attendance at Alcoholics Anonymous meetings (p. 77). Antabuse is a drug that has no harmful effects while abstinent, but

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[4]Denial is defined by Barker (1999) as "The *defense mechanism* that protects the personality from anxiety or guilt by disavowing or ignoring unacceptable thoughts, emotions, or wishes" (p. 122).

produces nausea when alcohol is consumed while Antabuse is present in the body. When this theory did not explain the relationship of alcohol use and other illnesses, symptomatic theory was developed.

Symptomatic Theory

This theory is innovative because it describes alcohol and/or drug misuse as a symptom and not the primary disease. Kissin (1977b) states "alcoholism is a symptom of a variety of pathologies, each one of which might be considered as a different illness" (p. 8). This is reiterated in Program Standards where substance misuse is depicted as "a symptom of another primary mental disorder, e.g., anxiety, depression, neurosis, personality disorder" and "treatment of the underlying psychiatric disorder will lead to remission of substance misuse. Therefore, attention is focused on diagnosing and treating coexisting psychiatric illness" (Alcohol and Drug Programs, 1987). A Committee of the Institute of Medicine (1990) cites the results of two studies (Braiker, 1984; Beckman and Amaro, 1986) which reveal women who misuse alcohol are more likely than male counterparts to have primary affective disorders (p. 357). This means that women who misuse alcohol are more likely to receive mental illness diagnoses than men who misuse alcohol. Women would then be dealing with two separate issues: one regarding mental illness and the other, alcohol misuse. Women, therefore, are more likely to approach mental health professionals for help while their male counterparts are less likely to become involved in mental health organizations.

Social Theory

This theory suggests that sociocultural forces, such as, ethnicity, class, gender, and war are key in determining the origin of drinking and drug use. Social context is seen as the source of the problem, drinking and drug use are means of coping (Beigel & Ghertner, 1977; Kinney & Leaton, 1991). As Beigel and Ghertner state, "the social rehabilitation model abandons as a primary goal trying to change an individual problem drinker so that he will fit into the society in which he lives. Instead, it focuses on changing the social context in which he lives" (p. 215). However, throughout the chapter, Beigel and Ghertner continue to promote change within the individual through short term relocation to another social context such as attendance at halfway houses, residential treatment and Alcoholics Anonymous meetings. This theory continues to address social problems on a personal level. Women are referred to residential treatment programs when professionals believe that women need intensive treatment strategies most effectively offered in a controlled environment.

Leaving home for treatment creates barriers for women. Blume (1986) lists issues of child care, cost of treatment, lack of support network and employment concerns as areas which impact access to treatment. More recently, the Centre of Excellence on Women's Health and B.C. Children and Women's Hospital participated in a joint research project in Vancouver and Prince George on barriers and supports for women who are pregnant and parenting when accessing treatment for drug use. A summary of their findings (Isaac & Poole, 2001) revealed shame, fear of losing children if they identified as needing treatment, fear of prejudicial treatment on the basis of motherhood/pregnancy status, feelings of depression and low self-esteem, belief that they could handle the problem without treatment, lack of information about what treatment was available, and waiting lists for treatment as barriers for women in getting

help for drug misuse. For my study, these social factors are articulated by the women I interviewed when they describe their experience of drug use.

Chemical Dependency Theory

Alcohol and drug misuse is defined as a syndrome which is marked by three components: an altered behavioural state, an altered subjective state and an altered psychobiological state as described by Lindstrom (1992) cited in Alcohol and Drug Programs (1987). Peele (1989) has argued eloquently that addictive behaviour should not be defined as a disease, thus calling chemical dependency theory into question.

Chemical dependency theory goes beyond the disease model as it adds a cognitive component and highlights personal agency. Chemical dependency is conceived as a continuum which acknowledges difference in severity of problems incurred by drinkers and drug users. As a result, the goal of treatment is not only abstinence, but may also include harm reduction strategies that reduce detrimental effects of drug use (Sanchez-Craig, 1993; Riley, 1993). Harm reduction strategies are designed to reduce the use of drugs through education, policy-making and health promotion (Addiction Research Foundation, 1996, p. 34). Concepts from a harm reduction orientation are present in the stories of the women who participated in my study. Another theory that was present in the stories of the women was learning theory which follows.

Learning Theory

The foundation for this theory lies in the notion that if drinking and drug-using behaviour are learned (and not a disease process), then these behaviours can be changed through further learning. Attention is paid to the origin of the learning, for example, media, family of origin,

and peer group, using a cognitive-behavioural approach (Justice Institute of British Columbia, 1996). McCrady (1984) argues that, "stimulus control procedures, alternate skills training and behavioral marital therapy are behavioral treatments which aim to alter the antecedents to drinking" (p. 439). As a result, treatment strategies include assertiveness training, communication skill development, looking for triggers for drinking and drug misuse and relationship work. The goal of treatment is either abstinence or reduced drinking and drug use. As a variety of factors revealed the complex nature of drinking and drugging, a more inclusive model was developed to incorporate the many diverse theories that had evolved over time.

BioPsychoSocialSpiritual Theory

A holistic approach is the cornerstone of this theoretical framework. As Wallace (1989) states, "Elements of conditioning and learning are surely involved in alcoholism, as are neurobiological processes, genetics, cognitive processes, family systems, society and culture" (p. 332). Alcoholism is still viewed as a disease, but is multidimensional (Wallace, 1989).

In addition, other authors (Justice Institute of British Columbia, 1996; Addiction Research Foundation, 1996; Alcohol and Drug Programs, 1987) do not explicitly state that alcohol and drug misuse is a disease, but do acknowledge biological components. This model incorporates other theories, particularly their contribution regarding the nature of misuse, and focuses less on causal determinants (Alcohol and Drug Programs, 1987). The Addiction Research Foundation (1996) under recommended intervention outlines: "no single treatment approach is appropriate for all people, a wide range of treatment options should be available, it is best to match the client with treatment that most closely meets her needs, strengths and situation" (p. 34). The Justice Institute of British Columbia (1996) states, "This model was

recently adopted as the guiding model for alcohol and drug treatment programs in British Columbia" (p.10). As a result, the BioPsychoSocialSpiritual model integrates many of the existing notions about drug use and proposes a variety of treatment modalities.

Discussion

In this section I have outlined traditional theories of alcohol and drug use in the literature based primarily on men's experience and treatment approaches designed for men. I have presented findings of the research on women and drug use where quantitative and qualitative studies seek to describe and understand women's experience with drugs. As I have shown, developments in research methodology have elicited new and sometimes contradictory information. Women and drug use as the subject of inquiry not only yields sparse information about their experience, but also exposes the limitations of the research and theories that seek to describe it. Still unanswered are the questions that I find interesting and important. The puzzle I am viewing is how drug use is known and how it is experienced by women. None of the research I reviewed approached the issue of women and drug use in a way that, in my opinion, gets at an understanding of how women identify that they are misusing drugs and the role institutions play in this identification. The way women talk about their experience with drug use has not been revealed in the literature as a topic for discussion. The studies I reviewed do not reveal how women come to talk about their experience with drugs in particular ways. My study seeks to show how women come to talk about their experience with drug use and how they come to understand the nature of women and drug use.

The Research Inquiry

I set out to articulate the work women do in deciding that drug use is a problem in their lives. In doing so, I had the following questions in mind: What knowledge have these women used to make this decision and where has this knowledge come from? Is this an individual choice, or are there prevailing notions about what drug use looks like for women? Where do these prevailing notions come from? How is knowledge about women and drug use socially organized by the organizations that play a role in the lives of these women? How is this knowledge then reflected in policies and practices that impact and organize the lives of these women?

In order to understand the experience of women who use drugs, I began by listening to the stories of their experience as a way into the social organization of drug use. I was curious about how current ideas about drug use were reflected in each woman's understanding of drug use and the language that she used to describe it. In understanding how knowledge is produced about women and drug use, I set out to uncover possible ways to make that knowledge more reflective of women's experience and more accessible to other women whose lives are affected by drugs and alcohol.

To summarize, I have explored in this chapter why the study of women and drug use is interesting to me. I have also outlined how knowledge of women and drug use has been grounded in research based on men's experience and has since developed over time using quantitative, qualitative, and feminist research methods based on women's experience. I have also shown that this does not get at how women come to describe their experiences with drugs in particular ways. In the next chapter I will describe how concepts about women and drug use demonstrate relations of power.

CHAPTER TWO: METHODOLOGY

Conceptual Framework

This conceptual framework serves as the guide to determine "in common" understanding of women and drug use and to organize the way in which the inquiry was conducted. Because the literature review does not reveal research approaches that examine how women come to describe their drug use in particular ways and how those ways both shape and are shaped by institutions, I decided to use Smith's (1987) institutional ethnography as my method of inquiry. I explain how I made this decision and how this approach fit with my research about women and drug use.

Moving toward How Knowledge of Women and Drug Use is Socially Organized[5]

Beginning in the experience of women, I explored the work that women do in identifying alcohol and drug misuse in their lives and how women and drug use is socially organized. In looking at this work, I examined the gap between what women know about their experiences with drug use and how institutions with policies, procedures, legislation and practices, understand drug use and organize the lives of women. I also made visible how organizations work to shape women's activities and to order their lives.

In moving from the position of counsellor to researcher, I studied how these institutions define and organize the lives of women and drug use. When I first read Dorothy Smith's (1987, 1990a, 1990b, 1999) work, I was struck by the similarities of her research approach and my counselling work with women. Her research method appealed to me. Mueller (1995) notes, "Smith's unique contribution to understanding everyday life has been to discover how ideas,

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[5] The social organization of knowledge is discussed in depth later in this chapter.

legitimated through coordinated discourses, organized knowledge and action" (p. 110). Smith investigates and explicates how institutions reify a particular knowledge influential in shaping our understanding and our actions. Smith's approach to inquiry offered me a way to examine how women come to describe their experience with drug use in particular ways, and to explore how institutions shape understanding about women and drug use and how these are related.

I was drawn to institutional ethnography for a number of reasons. First, Smith begins from the standpoint of women which is consistent with my feminist values. The inquiry begins where women actually live and experience their material world. Second, she does not remove the subject from the context in which she lives, which is consistent with my social work practice. Rather than placing women as the objects of study, their subjective presence in the material world is maintained. Third, the strong emphasis on revealing the social relations, evident among women who use drugs and the professionals and institutions set up to "help" them, would help me see more clearly the process of how "cleaning up" works. Weedon's (1987) definition of feminism is remarkably appropriate here and fits with my own view of feminist practice:

> Feminism is a politics. It is a politics directed at changing existing power relations between women and men in society. These power relations structure all areas of life, the family, education and welfare, the worlds of work and politics, culture and leisure. They determine who does what and for whom, what we are and what we might become (p. 1).

This fits with Smith's method of revealing social relations and practices of power as they are experienced by women. G. Smith (1990) states this notion in his work as a political activist from the standpoint of gay men and illustrates how Dorothy Smith's method is applicable for research with other marginalized groups: "[D. Smith's method] can be used by all individuals who stand outside political-administrative *régimes* intent on managing society" (p. 631).

I read Smith's (1987, 1990a, 1990b, 1999) work extensively to get a better understanding about this method of inquiry and how I might use it in my study. Herringer's (1997) article on

AIDS suicide helped me envision how the theoretical underpinnings of institutional ethnography may be used in practice. I continued to read and was impressed by Swift (1995) who, while using critical theory to focus her study, draws heavily on Smith's ideas, particularly regarding textual analysis of child welfare work. Because I was formerly employed as a social worker in child protection, the ways in which work is structured through time management and the practices around documentation seemed very familiar to me. I found myself revisiting some of my own questions about this facet of my work.

Two other researchers focused on women and drug use using institutional ethnography as their method of inquiry. White (1998) looks at the role of power and authority in child welfare worker-client relationships, while Smyth (1998) analyzes the representation of women who drink alcohol using William Hogarth's 1751 *Gin Lane* engraving as an example of how these women are perceived. While these two studies are valuable, they do not explain why women describe their experience with drug use in particular and consistent ways.

Institutional ethnography has been used to examine the social organization of neglect (Swift, 1995); teaching and health (Manicom, 1995); HIV/AIDS and accessing treatment (G. Smith & Mitchell, 1991; D. Smith, 1995), suicide (D. Smith, 1990a; Herringer, 1998); and women and mental illness (D. Smith, 1990a). Campbell and Manicom (1995) helped me see how institutional ethnography was used in a variety of settings. Reading how other authors described their work and how they had implemented institutional ethnography in each setting gave me some ideas on using this method in my work. My research "puzzles" how drug use comes to be known and how it is experienced by women. Institutional ethnography allows me an excellent vantage point from which to look at the social organization of women and drug use.

Key Features of Smith's Method of Inquiry

To describe the key features of this method, I begin with the social organization of knowledge.

Social Organization of Knowledge

Institutional ethnography is a strategy to show how knowledge about society is socially organized. The social organization of knowledge is described by Smith (1990a) as, "a formalized impersonal mode of knowing articulated to (and indeed an integral part of) an apparatus of ruling" (p. 142). Smith's approach helps to articulate the disjuncture between this impersonal or professional way of knowing and "how people experience, tell, and make sense of what is happening from within the particular times and places of their lived actuality" (p. 142). As I have described in Chapter One, knowledge about women and drug use describes, interprets and predicts the behaviour of women, and informs the practice, policy and programs of institutions that order the lives of these women. For women who use drugs, this professional knowledge also shapes their thinking and organizes their behaviour in their everyday lives. However, these women experience a rupture between their everyday activities in their material world and what is described, interpreted, and predicted by knowledge about women and drug use that is created and exists outside their local settings. For example, in my professional practice, women often referred to their drug-using experience as the exception to the rule, or, they said that their experience was different from what they had anticipated. As I have previously stated, some of this general knowledge about drug use is extrapolated from evidence garnered from research based on men's experience. Smith's method begins from the standpoint of women.

The Standpoint of Women

Smith (1987) states, "We start, as we must with women's experience (for what other resource do we have?); the available concepts and frameworks do not work because they have already posited a subject situated outside a local and actual experience, a particularized knowledge of the world" (p. 109). Smith emphasizes that the foundation of this work begins with the stories women share about their everyday activities. Interviews I conducted with the five women who agreed to participate in the study served as the foundation for my research. Smith (1999) explains:

> Women's standpoint as a place to begin an inquiry into the social locates the knower in her body and as active in her work in relation to particular others. In a sense it *discovers* the ruling relations. They come into view from where she is in the actualities of her bodily existence, as relations that transcend the limitations of the embodied knower" (p. 4).

The standpoint of women then is the place to begin inquiry. I wanted to understand the rupture that occurs between women's understanding of their drug experience and the way drug use is understood by the professionals they come in contact with. I began by asking the women in my study about their experience with drug use. For Smith, the standpoint of women is important because women's experience had initially been excluded from sociological research. She argued that the field of sociology was founded on male experience and ordered, interpreted, and organized by male sociologists. Smith has determined to include women and their experience in her discipline. In much the same way, I wished to include women's experience with drug use in the male dominated alcohol and drug literature.

Institutional Ethnography

The cornerstone of institutional ethnography as a method of inquiry into the social organization of knowledge lies in Smith's (1987) two important questions, "How does this happen to us as it does?" and " How is this world in which we act and suffer put together?" (p. 154). These two questions served as a guide as I sought to discover and uncover the practices that shape the lives and the understanding about women and their drug use.

The aim of institutional ethnography is to "explicate the actual social processes and practices organizing people's everyday experience from a standpoint in the everyday world" (Smith, 1987, p. 151). Smith (1987) outlines four key features of the work:

a) people participate as subjects of the study,
b) the research examines actual activities of actual people,
c) the research explicates how these activities are organized as social relations, and
d) the research discloses how activities are articulated to the social relations of the larger social and economic process (p. 151-2).

As a research strategy, institutional ethnography begins in the everyday world of the subject. Observation, interviews and documents become the data that serve as "entry" into the social relations (Campbell, 1998, p. 57). For example, George Smith chose to use meetings, events and conversations as data in his work on accessing treatment for AIDS (Smith, 1995, p. 29). He talked to professionals, politicians and bureaucrats involved in the ruling regime, and information was gathered regarding the social policies and practices of those agencies and their strategies for change. Pertinent documents were examined to make the social processes explicit. Kinsman (1995) used regulatory texts and legal practices to examine sexual policing and gay men (p. 81), while Swift (1995) in her work on child welfare, worked with documentation (file recordings) from the agency and examined standard practices of the institution (p. 35). Miller (1997) writes a gripping exposé of palliative care using her personal experience of the death of

her partner, recordings in her journal, and other documents such as consent forms, file recordings and a palliative care manual which she calls, "The Holy Binder." I now explain how analysis is done using the analytic procedure, "social relations."

Social Relations

By using social relations as an analytic tool, I examine how women's lives have been ordered and organized by social processes outside or behind the local site in which they experience their lives. Smith and Mitchell (1991) describe social relations in this way:

> People's lives do not exist in a social vacuum. When individuals apply for welfare, for example, they are entered into an institutional course of action over which they have limited control. This course of action organizes them in relation to their friends (e.g., money for socializing), their landlord (e.g., their ability to pay rent), their social worker (e.g., determining their eligibility for welfare), and the federal, provincial and municipal government (e.g., providing the necessary cash allowance)--to name just a few organizational features of this course of action. So the notion of social relations guides the analytic work of the researcher in identifying and describing institutional courses of action (p. 13).

Smith and Mitchell describe how we function in a local material bodily way through our actions, and in doing that, we respond in an ordered way to our ordered environment. Because we always work in relation to other people and organizations in society, our responses are ordered and organized as well. In looking at these ordered activities, our actions both shape and are shaped by institutions outside our control. Social relations is the concept that exposes the coordinating feature that orders our activity and is a means of analyzing those relationships.

Smith (1990b) describes social relations:

> The notion of a social relation or extended social relations as sequential and replicable courses of social action involving more than one individual should not be conceived as subject to examination as such. Rather it offers an analytic procedure enabling local instances to be situated in terms of their role in the movement of such a social course of action (p. 222).

In my study, I make use of the notion of social relations when I uncover how women's activities are shaped and coordinated by social processes they do not control. To begin in women's experience with drug use provides a point of entry into the social relations that organize and coordinate the activities of these women. Social relations occur at that point where activities in women's everyday experience and institutional social processes meet. As women's activities enter into social relations, their activities take on a social form that is prescribed by other social processes.

In examining the social organization of women and drug use, I looked and listened to their stories for similar visible and hidden processes that shape how women coordinate their daily activities. Their talk about their activities reflect what they've learned about drug use, seeking help and "cleaning up." For example, when women seek help from an alcohol and drug agency to quit using drugs, they enter an intake process that allots a specific time, a place and event in which information is both given and received. In essence, they receive training in how to access help from the organization. The agency organized its activities to meet the mandate, to be effective, to be efficient in the use of the worker's time and to allocate resources economically. In this way, women's activities are coordinated to meet the needs of the agency.

Looking at that social relationship, Smith (1990a) is very specific, "The basis of analysis is not the act, the action, or the actor. It is the social relation coordinating individual activity and giving people's activities form and determination. What an act is may be grasped in any way we can, but it takes on determinate social form as it is entered into a social relation" (p. 94). For example, when I heard women in residential treatment say, "I'm here for me," the basis of analysis is not what was said, how it was said or who said it. My task is to analyze how it came to be said in that particular way by tracing the social relationships among the women, the

professionals, and their institutional mandate. How did it come to be that women knew to use this phrase upon entry into a residential treatment program? How did that phrase become the social form required in this situation or as I called it, the "coached correct answer," given that these women were from different cultures and communities?

Relations of Ruling

Knowledge is a necessary component of the exercise of power in contemporary societies, Smith argues (1987, p. 19; 1999, p. 94). A particular organization of knowledge both shapes and is shaped by the ruling apparatus which Smith (1987) describes as:

> ...that familiar complex of management, government administration, professions, and intelligentsia, as well as the textually mediated discourses that coordinate and interpenetrate it. Its special capacity is the organization of particular actual places, persons, and events into generalized and abstracted modes vested in categorical systems, rules, laws and conceptual practices (p. 108).

The ruling apparatus implements and standardizes processes and discourses across many sites of practice. As women who use drugs talk about their lives, they reveal that institutions such as child protection agencies and the police not only shape their ideas about drug use, but also organize their activities. Concepts women use to describe their experience with drug use reveal relations of ruling. For example, women in residential treatment for drug use often label themselves as bad mothers because authority figures have told them they have chosen drugs over their children.

Relations of ruling are imbedded in written policies and practices within government services and are also apparent in legislation and practices of law enforcement agencies. Other institutions like the medical profession and health care system as well as self help groups like Alcoholics Anonymous, Alanon, and Narcotics Anonymous also structure the way women

understand their drug use and come to explain their experiences. Given this direction for analysis, "...the issue is how activities are organized and shaped extra-locally, as work processes given form and purpose by social relations, relations felt but not seen" (Heap, 1995, p. xii), I identify those social relations that shape, organize, and order the lives of the women in both visible and hidden ways.

However, this is not the study of unique personalities within these systems who, as individuals, respond without guidelines or restraints. Agency representatives do just that; they represent or embody the policies, practices, and ideologies of the institution. Their work is organized and governed by those agencies that function as part of the relations of ruling. Miller (1997), a social work graduate student, describes the dilemma faced by palliative care workers:

> My analysis also helped me to see how the textually mediated process of helping constructs the workers involved as much as it does the clients or patients. This bridged the gap between my sense of most workers being competent and caring, and my overall experience of being objectified and misinterpreted. The organizational experience of discourse-oriented constraints and limitations on the worker's practice, as I have demonstrated through documentary analysis, may result in her own conscription as an agent of a process which I have described as both colonizing and objectifying. The worker's caring and helpful intentions can be overwhelmed by a process that is unable to address individuality in any useful way (p. 96).

Miller is identifying ruling practices that are prescribed in palliative care and as such, take precedence over individual workers' notions of responding in any but an institutionally authorized way. The actions of agency representatives are both limited and monitored so that they serve the needs of the agency in a predetermined and predictable way set out by the organizations that employ them.

Listening to the Voices of Women: Exploring "In Common" Understanding

Smith and Mitchell's (1991) research proposal helped me become more systematic and intentional in articulating how institutional ethnography could be used in my own research about the social organization of women and drug use. On reading the verbatim statements of female university students (Isaac, 1991), gay students (Smith, 1998) and lesbian, gay and bisexual youth in group homes and shelters (O'Brien, 1994), I decided to include transcript excerpts in my study as a way to strengthen the presence of those I interviewed. In his work on the school experience of gay students, G. Smith (1990) states, "As exhibits, the excerpts create windows within the text, bringing into view the social organization of my informants' lives for myself and my readers to examine" (p. 312). Keeping the voices of the women in the text takes me back to them as subjects in the inquiry, and encourages me to examine "practices of knowing" (Smith, 1990a, p. 11). Hearing their voices reinforces the standpoint of women that guides my work.

Concepts as Practices

Manicom (1988) says, "I have found it helpful...to remind myself that concepts are practices. To constantly think concepts-as-practices keeps in view their construction, their histories, their constitutive work, their activities" (p. 69). To explore "in common" understanding about women and drug use and how experience is socially organized, I start with women's experiences. These experiences take place in their actual lives as they live them materially in the world and in their bodies, at some particular time and in some unique location (Smith, 1987, p. 123). For women to present information about their drug use, they must convey and direct meaning that is consistent with another's understanding. This conceptualization of their experience with drug use is necessary for discussion and shared comprehension with

professionals. To see concepts as practices is to reveal how concepts include and exclude information about women's experience with drug use in predetermined ways. For example, when women conceptualize their drinking as alcoholism and this is viewed as a disease, harm reduction strategies like controlled drinking are not options, because the disease model demands abstinence. The concept of drug use as a disease, then, is a practice that regulates information and prescribes action for women. Smith talks about how she learned to talk about her field of study, sociology.

Smith (1990a) describes how she learned as a graduate student what topics were relevant to sociology and those that were excluded, "We learn to discard our personal experience as a source of reliable information about the character of the world and to confine and focus our insights within the conceptual frameworks and relevances of the discipline" (p. 15). In much the same way, women who use drugs, in describing their experiences, learn what is relevant information and what parts of their lived experience must be excluded. At this point then, there is a gap between what women experience in their material lives and how it comes to be known.

Similarly, when institutions conceptualize women and drug use in particular ways, this orders and organizes the work that they do with women. This conceptualization is reflected both in the practices and the documentation of the institution. It forms the institutional account of women and drug use which instructs both professionals and the women about how, when, and what work must take place with women who use drugs. In this way, concepts become practices of ruling. The particular ways that institutions choose to conceptualize women and drug use also demonstrate practices of ruling, validating preferred concepts while rejecting others. As Smith (1990a) clarifies, "The concept becomes a substitute for reality. It becomes a boundary, a terminus through which inquiry cannot pass. What ought to be explained is treated as fact or as

assumption" (p. 43). Concepts, then, become practices of ruling that hide taken for granted notions about women and drug use.

In my inquiry, I examine women's talk about their lives including their drug use. In their stories I look for how common understandings occur and how the institutions and practitioners play a part in shaping those understandings. Enacted together these events constitute the social relations that shape women's lives.

Method

The following section presents the ethical considerations, and the research method, and articulates how the analysis was done. It shows how I conducted this inquiry and the preparation taken to ensure ethical procedures were followed. How I plan to share information about the study completes the chapter.

Ethical Considerations

I participated in three ethical review processes for my thesis. As a Master of Social Work student, I submitted a thesis proposal to the University of Northern British Columbia Review Ethics Board. As a researcher in the alcohol and drug field, I submitted a summary of the thesis proposal, as requested, to the Community Services Manager for the Ministry for Children and Families. As an employee, I submitted a thesis proposal to the Research Review Committee of the Prince George Regional Hospital. I received written approval (Appendix A) to conduct this research from each of these institutions.

One ethical consideration I had was entering into a dual relationship as therapist and researcher. Barker (1999) describes the dual relationship in clinical social work as, "the

unethical practice of assuming a second role with the client" (p. 141). This could occur if I were both the current primary counsellor in a professional capacity with a participant in this study and also researcher in this study. This means that I could have a conflict of interest within the therapeutic relationship and that women would be in a position of greater vulnerability, feeling forced to participate in either research or therapy or both. The women who participated in this research did so voluntarily and were not concurrently in a counselling relationship with me. In my counselling experience, women sometimes revealed that children were at risk.

If our conversation reveals that a child was at risk, I am responsible for reporting my concern to the appropriate authorities. As a researcher, I explained my duty to report any concerns regarding the safety of children that may come up in the interview. It was imperative that this be explained to each woman prior to the interview so there were no misunderstandings about my legal obligation. This was included in the Letter of Informed Consent for Women (Appendix B), which was signed upon explanation and agreement prior to the interview taking place.

Regarding possible adverse effects, there may have been some areas around alcohol and drug use that the women found sensitive. I told each woman that she need not continue the interview and could end it at any time. Again, this was included in writing in the Letter of Informed Consent (Appendix B). If necessary, I arranged for other counselling resources to offer assistance, but this proved to be a precautionary measure not utilized.

If there were any concerns regarding this research, both my Thesis Supervisor and myself were designated to respond. The Office of Research and Graduate Studies at the University of Northern British Columbia was prepared to field any complaints. Participants were advised in

writing in the Letter of Informed Consent for Women and the Letter of Informed Consent for Agency Professionals (Appendix C).

Research Design

I used the following design to conduct my research. Because I am looking at how drug use comes to be known and how it is experienced by women, I spoke to women, and to professionals and I examined documents used by those agencies that worked with women who use drugs.

The Women

I posted an Information Sheet for Women (Appendix D) in four different locations requesting volunteers for this research project: at alcohol and drug service agencies, social service organizations, child welfare agencies and health organizations. Women then called me at home to inquire further about the research. After some initial discussion to clarify requirements for participation in the research, I selected the five women who best fit the criteria; women who identified alcohol and/or drugs as a problem in their lives, were in recovery, and who wished to understand more about women and drug use in society. One woman, although initially interested in participating, did not call back to set up an interview time as we had arranged and so was excluded from the study. Three women were excluded; one who called after I had already chosen five women and two women who had been in recovery for many years were excluded as I wished to look at the current social organization of women and drug misuse. While this would have brought a richer historical aspect to the project, I felt I needed to set some

limits. Every woman who called me to participate met the criteria. I arranged an individual appointment time and a convenient place to conduct the interview with each woman.

Each woman was given a package consisting of an Information Sheet for Women (Appendix D), a Letter of Informed Consent for Women (Appendix B) and an Interview Guide for Women (Appendix E). Although literacy was not a problem, I explained the research project again, read aloud the Letter of Informed Consent for Women and had each sign it upon her agreement to participate. I audiotaped and transcribed each interview. The interviews ranged from one to two hours in length. The open-ended interview questions were designed to give each woman the opportunity to tell her story in her own words, consistent with good feminist research practice (Reinharz, 1992).

To begin, I asked each woman to describe how she experienced drug use in her life. I wanted to find out how she talked about drug use. I also asked each woman to describe how she quit using drugs as I explored how organizations are implicated in her decision to "clean up." Each woman received a transcript of her interview to check for accuracy, and three women chose to keep a copy of the transcript.

The five women interviewed were between 27 and 48 years old. Each woman had between two and five children. In stating their drugs of choice, two primarily used heroin, one used alcohol, one used cocaine, one used Talwin & Ritalin (Ts & Rs). All had experimented with other drugs. Two women had actively engaged in prostitution, some had sold drugs, and some had engaged in stealing and shoplifting to support their drug habit. Two were First Nations women and three were of Euro-Canadian backgrounds. Education levels ranged from Grade Ten completion to almost University graduation.

Of the five women I spoke with, three had given care and custody of their children to relatives, two had relinquished custody of their children through a legal process and one had ongoing intervention by the Ministry for Children and Families. None of the women had used drugs or alcohol for at least six months at the time of the interview. In order to ensure anonymity, they were asked to choose pseudonyms, as this created a more personal connection with the reader than other protocols, such as "respondent one." Some chose to use a pseudonym, some chose to use their own names. To maintain confidentiality, I have not linked unique identifiers to names where possible. The women who participated were Tara, Veronica, Shanna, Cathy and Anne.

The Agencies

Because I wanted to explore how professional knowledge and organizations work to shape these women's activities, I interviewed representatives from three different agencies reported by the women as most influential. These individuals were not named specifically nor did they necessarily have direct contact with the women. For example, I did not speak to the individuals that the women called their "counsellors" or their "workers." I interviewed two social workers and one law enforcement officer who were chosen through telephone contact as those individuals interested in participating in this research study. Early conversations with each representative included a description of the research, the request for an audio-taped interview as well as access to agency forms, intake forms, mandates, and written policies. Upon agreement, an appointment time and place were arranged. Each representative received a package of the Information Sheet for Agency Professionals (Appendix F), Letter of Informed Consent for Agency Professionals (Appendix C) and Interview Guide for Agency Professionals (Appendix

G). The Letter of Informed Consent was then signed, one copy for my records and one that they could keep. The interview was then audio-taped.

In the first interview with one agency representative, I failed to record the second half of the interview because I pressed "play" on the tape recorder instead of "record." A second interview was requested and completed. All interviews and the first portion of one interview were then transcribed and given to the agency representatives to check for accuracy. In the interviews, I asked the professionals to describe how they work with women who use drugs. I explored practices such as counselling, referral, and risk assessment performed by each agency. Other agencies such as Alcoholics Anonymous were questioned as required on an informal basis to gather information about practices and guidelines used in their work with women who use drugs.

The Analysis

I began by transcribing the interviews with the women and after having the women check them for accuracy, I made corrections and read the text of each transcript several times. I then looked at how women talked about their experiences with drug use and noticed how they described them. I looked at how they learned these ideas. Because I asked them to describe what they did to quit using drugs, they revealed institutions that were pivotal in understanding their drug misuse. I paid attention to the concepts they used about women and drug use as they described their everyday lives. I wanted to know how their activities were organized and ordered by social processes. Smith (1987) describes this procedure:

> We begin with a knower, a subject, whose everyday world is determined, shaped, organized by social processes beyond her experience and arising out of the interrelations of many such experienced worlds. They are relations that coordinate and codetermine

> the worlds, activities, and experiences of people entered into them at different points (p. 134).

I began with passages from the women's stories that stood out for me and examined them closely. I considered how women learned to describe their drug use in a particular way that I could recognize as "in common" understanding. I looked at how their understanding about drug use had been shaped and their activities ordered by social processes. I examined the "gap" between how women talked about their lives and how their experiences are described by professional organizations. I examined the relationships I saw in the "gap."

As previously stated, I spoke to representatives from the three agencies who were available to do the interview and willing to participate in the research. I read the transcripts several times. I requested further information from these and other organizations as I continued my analysis. I then tried to find links between the concepts women use to describe their experience in drug use, as well as their activities in using drugs and quitting drug use, and policies, procedures, protocols and practices that the agency representatives had mentioned.

In the interviews with agency representatives, I used the notion of social relations to examine their work with these women. I accepted that the documents each agency uses, such as assessment forms, intake forms, and policies are part of social relations. The documents both inform and guide expected courses of action for the women and for the agency representative. The use of these documents structures how meaning is made and coded for the organization from actual events. In identifying specific information, the documentation elicits specific data and I can follow the organization's use of this information. It links people and activities. In looking at how Marx's analysis of ideology could apply to sociology, Smith (1990a) explains, "The ideas, concepts, and categories in which the ordering of people's activities becomes observable to us are embedded in and express social relations" (p. 38). When documents are

used to collect information, what has already been organized is the social form that the data takes. Agency representatives explicated the policies, practices, and procedures within the institution. Written documentation standard in service delivery was given to me for analysis. Their transcribed interviews and the documentation show the social relations of professional response to drug use. Social relations is an analytic procedure to look at how women's interactions are shaped by social processes and their activities take on social forms.

Subsequently I expanded my analysis from local sources, the women and agency representatives, to provincial and federal documentation that governs and determines local action. I continued to explore literature on women and drug use and link that information into my study as well. Learning more about social policy and its role in the social and economic process that affect women and drug use was the next step. I continued this process using several experiences from each of the women's lives. I chose particular experiences for my study when they most clearly showed how these women understood drug use, how they made decisions about their activities around using and not using drugs, as well as showed how their actions were influenced and organized by institutions, policy and practitioners.

Dissemination

When my thesis is complete and approved, I plan to distribute a copy to each of the women and agency representatives that participated in this inquiry. A copy of my thesis will be available at the University of Northern British Columbia Library for loan. I also have been approached by others, such as social work professionals interested in this work and plan to make my findings accessible.

Findings are presented in the following chapter. To paraphrase Smith (1987), I want to show how this world is put together in the lives of women and drug use and how things happen to them as they do (p. 154).

CHAPTER THREE: FINDINGS

This chapter presents three arguments from interviews with women, professionals and from agency documents. First, I argue that women do "medical work," "social skills work," and "moral work" when they talk about their experiences with drug use. Second, I argue that the actual lived experiences of these women have been marginalized and excluded from the institutional account and, third, I argue that these conceptual practices preserve inequities in relationships of power between institutions and women who use drugs.

While drug-using women have experiences in their daily lives which they attribute to their drug use, the ways in which they talk about their experience with drugs is a conceptualization based on that experience. As women describe their experience, they cannot relate it without working to set some specific parameters, indicated by the words they use and "in common" understanding that others recognize. Because that "in common" understanding is often taken for granted, what is included and what is excluded is often hidden and remains unexamined. For example, when women talk about withdrawal, they do "medical work" as they describe their experience with words related to illness and disease so that others, particularly professionals, may understand their experience. Consequently, withdrawal becomes a medical concept.

Looking for the work that women do in talking about drug use, I was able to see in the accounts of the women ways in which they understood women and drug use. Three concepts, "medical work," "social skills work," and "moral work" emerged from the transcripts as work women did when describing their experience.

Concepts determine and are determined by "in common" understanding and these concepts then shape how women and drug use is understood. Concepts are used to define and

describe particular instances. Concepts can be prised apart to reveal relations of power (Manicom, 1988). As practices of power, however, concepts then may be used to confirm or deny women's experience with drug use. What results is a gap between the concepts about women and drug use used by professionals and women's actual experience. This gap is the difference between what a woman knows about her experience with drug use and the concepts she has available to do the work of describing that experience as it is understood and accepted by others.

Once a woman is defined by an authority as having a drug "problem," she enters into a world or a series of relationships already in place. "Women and drug use," as conceptualized by institutions, informs the practices, policies, protocols, and procedures of organizations and is made explicit in the textual documentation of organizations. The documentation of organizations reveals how women and their drug use are understood by institutions. In the institutional account I examine in my study, a particular, authorized conceptualization constructs both the documentation and work of the organization. As a result, concepts become practices of ruling, including and excluding particular notions about women and drug use, and these practices of ruling organize institutions to perform and textually reproduce their work with these women in specific ways. To show how this works as a dominant relation, I examine how women and drug use have been conceptualized in the institutional account by looking at transcribed interviews of agency representatives and agency documentation and also through interviews with the women. To demonstrate, I draw on interviews of women, professionals, and agency documentation to show the work that women do in articulating their experience with drug use and how organizations shape and regulate women's activities.

I set the scene for my arguments with a discussion of drug use as acceptable and unacceptable behaviour in our society. Using measurement and assessment tools, alcohol and drug professionals determine if women meet the criteria required to access agency services. I use this discussion to create the context where the work of women is required to meet the demands of the agency. Women may seek professional help to determine if their drug use is deemed to be acceptable or unacceptable.

Acceptable Use: Experimentation, Social Use and Controlled Use

To differentiate between acceptable and unacceptable use, institutions create strategies to separate moderate drug use from excessive or problematic drug use for women. The relations of ruling are revealed in both the construction of these concepts, how women and drug use is understood, as well as the organization of work in regulating drug use. Acceptable drug use was described by the women and I was able to distinguish three categories of drug use that are tolerated and even condoned.

Experimentation

In our society, most young women have tried their first drink and possibly used their first drug, commonly marijuana, before they reach the age of majority. Although parents may caution children about drinking and driving and other concerns related to drinking and drugging, use is conceptualized as experimentation and is not construed as a problem. Parents often reminisce about their first experiences using alcohol and drugs, and use is typically understood as a rite of passage into adulthood. The women I interviewed describe their initial introduction to alcohol and drugs as experimentation:

> I started sneaking into the bars when I was 15 and my mom used to come and chase me home (Veronica).
>
> ...when I first started doing drugs I was 19. I experimented with speed... ...so I started experimenting with heroin...but it was just something I'd do once every two, three months. ...I experimented with coke (Shanna).
>
> You know, lots of testing out, I've done acid and pot and stuff. ...I tried [cocaine] once...(Cathy).

Trying out alcohol and drugs was the norm during adolescence for participants and their peers. In using the term "experiment" and "test" to describe their activity, an assumption is revealed that this use is considered somewhat harmless and is condoned as a normal stage in the lifespan.

Furthermore, use of the word "experimenting" suggests that trying something new to determine the effect is a natural response to curiosity. Prevailing attitudes are revealed in the notion that this use is associated with a developmental phase, adolescence, and that youth will outgrow or moderate their use. Addiction Services' professionals collect information from those who receive services and ask "age at first use" for each drug on the Addiction Information Management System (AIMS) – Outcome Measures form (Appendix H) which is "used to identify trends in the age of onset for use" (Ministry for Children and Families, 1998, p. 7-4). This information has been used to develop prevention strategies for alcohol and drug misuse by providing information and education to specific target groups, often facilitated by alcohol and drug counsellors, police officers, and other community members in school based programs. However, total abstinence may not be the goal as some use, often termed 'responsible' use, is deemed acceptable in our society.

Social Use

Drinking alcohol is encouraged in many social situations, such as parties, bars, and sporting events. Smoking marijuana is becoming more accepted in some social circles, and legislative challenges seek to decriminalize cannabis use. As the RCMP representative told me, "The border with marijuana use is open for debate, it appears to me in Canada, even to the point of, should it be legalized, shouldn't it be legalized? ...the police are told to obey the law. The police are allowed a lot of discretion in terms of that." Drinking and using drugs as recreational activities have become the norm and are often experienced as enjoyable. Women in the interviews said:

> It was one big party for years (Anne).
>
> So, to me, it was party. It was payday, go out and drink, whatever (Cathy).
>
> I was a social user in a lot of ways... ...Then I was a social drinker for a while and I'd use drugs once in a while but very socially and very casually and that carried on for a long time. ...I had quit pot when I was eighteen or so and I had quit alcohol at various times, too and I was just a social drinker. I didn't drink to excess or very rarely because I blacked out...(Tara).

Social use also implies harmlessness, choice and controlled use; being able to stop using, not using excessively, and using only in designated social settings.

Controlled Use

Attention to how use is controlled draws into view the social relations. As Tara states, "In the beginning, I could shut down [stop using the drug] at a certain time." She makes conscious choices about her drug use. But these decisions are also determined by rules of conduct regarding drug use that are professionally and legislatively enforced.

While age is a limiting factor that varies from province to province, in British Columbia, nineteen is the legal drinking age and authorizes purchase and consumption of alcoholic beverages. The provincial government controls the sale of alcohol through liquor distribution stores in the province and receives remuneration through licencing, taxation, and sales. Licencing and regulation govern where groups of people may consume alcohol, how many may consume alcohol on the premises, and days and hours when alcohol may be consumed. Who is authorized to sell alcohol and how much alcohol they are allowed to sell to individuals are also regulated and enforced by law.

So, in British Columbia, because the alcohol industry generates revenue for the provincial government, social drinking is facilitated but regulations delegate responsibility and liability for alcohol use back to individuals who drink, individuals who sell alcohol, and proprietors of establishments where drinking occurs. However, when controlled use is conceptualized, it is taken for granted as meaning personal responsibility for use and is often labelled responsible use.

To confirm this perception, I looked into the procedure of obtaining the Special Occasion Licence. The Application, Regulations and Special Occasion Licences brochure (Appendix I) illustrate how social events are organized and regulated when "planning to serve or sell alcoholic beverages at a special event." Events are categorized as family, private, public or manufacturer promotion and the cost of each is discerned. Personal information is required, the Serve It Right certificate number is mandatory when required for personal liability. The host organization is also accountable and named. Details indicating location of event, designated area of liquor consumption, as well as date, number of participants and time of the event are recorded. Sale prices are differentiated and must be predetermined, and only alcohol sold by the Liquor

Distribution Branch (LDB) is allowed, with maximums previously set by this regulating body. Authorization by the LDB Store Manager and the RCMP validate the application. The applicant affixes his or her signature and the date of request and keeps the original which is later attached to the licence when issued. Copies of this document are given to the LDB Store Manager and the RCMP. Payment is also required prior to licencing. This documentary process shows how alcohol use is regulated and managed systematically through a process outlined and categorized by the Ministry of Attorney General and the Liquor Control and Licensing Branch. Fees for service are required to pay to process the paperwork and to ensure what has been delineated occurs. Enforcing the regulations that these documents put in place requires the involvement of the RCMP and liquor inspectors. Should any of these regulations be violated, use may be deemed unacceptable and result in licence invalidation or prosecution.

Unacceptable Use: Measurement and Assessment

Drug misuse is an arbitrary point defined by professionals. Use exists on a continuum from abstinence to continuous use. Drawing the line where women's drug "use" becomes "misuse" is not exact, although professionals use measurement tools to define and quantify drug misuse. This institutional measurement process is called assessment.

Measuring Alcohol and Drug Use

In order to determine what constitutes misuse and to assess the need for alcohol and drug services, women wishing to access addiction counselling services are required to participate in testing procedures. Measurement tools are designed to indicate increases and decreases in drug use, and to set limits for acceptable drug use.

> I was honest with [my drug and alcohol counsellor] telling her about what I was doing, using and everything (Cathy).

Women who receive Addiction Services are asked about their drug use. They are instructed to provide information that the agency has deemed valuable to indicate that drug use is reduced and that change has taken place, and agency services have met their needs. This information may be used to help women see change in their drinking and drug use and is entered on a form that is designed to measure outcomes at various times.

The AIMS--Outcome Measures form (Appendix H) was introduced in November, 1998 to assist professionals in "collecting information on Addiction Services program demographics and utilization" (Ministry for Children and Families, 1998, p.1). This form documents the type and quantity of drug use for individuals. Here, gender information is required. Conceptually, Addiction Services has discerned gender to exist in three categories, 'M' is for Male, 'F' is for Female, and 'T' is for Transgender, as articulated in the procedure for filling out this form (Ministry for Children and Families, 1998, p. 2-6). While these categories are not explicitly defined, this is a mandatory section on this form. The rationale given by the institution for requesting this information reads, "Required for Federal/Provincial Cost Sharing Employability Assistance for Persons with Disabilities (EAPD). Required by Treasury Board for clients accessing problem gambling programs" (p. 7-3). Consequently, this small segment of the document reveals the social relations and the economic and social processes where they intersect when women are directed to complete this document. Women become an identifiable group, distinct from males and transgendered individuals and information about them is gathered meeting the various regulatory requirements of these organizations.

On the document, misuse is categorized as excessive alcohol use. Excessive alcohol use is defined as three or more drinks for women per day and five or more drinks for men per day.

Moderate use is one to two drinks for women per day and one to four drinks for men per day. Information regarding excessive use by those identified as transgendered is not articulated. Each drink is defined (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999) as:

> A standard drink in Canada refers to a beverage containing 13.6 g of pure alcohol: one 12-oz. (341 mL) beer (5% alcohol), one 5-oz. (142 mL) glass of wine (12% alcohol), 3 oz. (85 mL) of fortified wine or 1.5 oz (43 mL) of spirits (40% alcohol) (p. 25).

Alcohol use is measured as the number of days excessive and the number of days moderate alcohol use occurred in the past thirty days. While excessive alcohol use is differentiated by gender, stereotypes are being used as a standard. This assumes that all women respond to alcohol in the same way, which contradicts Pape's (1993) findings of difference in intoxification levels and alcohol tolerance for body fat to muscle tissue ratio and menstrual cycle variation. Although findings indicate individual difference in women, only the above standard for men and for women is reflected in the AIMS data. However, drug use is measured differently.

Each specific drug taken (excluding taken-as-prescribed medication) is noted and measured by the number of days in which drug use occurred in the past thirty days. Professionals at Addiction Services gather this information at three separate times: at intake when women come in for assessment and to access alcohol and drug services, at discharge when service delivery is complete, and at followup which is a set period of time after discharge. Effectiveness of services provided is indicated when data show that individual drug use has decreased from the initial intake date to the discharge date and maintained over time until the followup date. This is one method used by this organization to determine whether change in drug use has occurred. It is assumed reduction in drug use results from services delivered by the organization, one goal of Addiction Services agencies.

This shows how women's alcohol and drug use has been quantified and portrayed as data to meet the needs of organizations in defining drug misuse through a documented process. It also illustrates how this information is then collected and used to evaluate the effectiveness of service delivery provided to women by those organizations.

Assessment for Service

Agencies that regulate and intervene in the lives of children and families such as health, social services, and criminal justice often require reports on women's drug-using behaviour. This may be to formalize access to subsidies for treatment, to trigger certain official responses, or to document requests and compliance with the authorized treatment plan. I present Anne's story to illustrate how the assessment process works. She is taught the correct procedure as she tries to meet the demands set forth by the court:

> They asked me to do [a residential treatment program] when I went to court for [my child] and one week after that I went up to the treatment centre and tried to sign myself in but I couldn't. (Laughs) They wouldn't let me in so I talked to my [alcohol and drug] counsellor. ...she said, "We have to do some appointments with you for two months, do counselling before you can sign in." So I did, I went to counselling with her, I joined the women's group that was downtown at [agency name] and I did that for a month and a half. Then I signed up for the treatment centre.

Sometimes professional and legislative procedures of professionals produce pressure for women to act quickly. Given the tight time frame[6] of the *Child, Family and Community Service Act*, women make demands to expedite residential treatment and one to one counselling to get their children back sooner or to avoid losing custody of their children permanently. While Anne is ready to comply with the legal requirements to get her child back, the organization of service

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[6] The child protection agency professional stated that the time between the presentation hearing and returning to court to decide if removed children are returned home is 45 days.

provision prevents her from attaining immediate access. Although the court may have set conditions for her that structure her relationship with her child, she is constrained by other professionals in meeting those demands, whose organization determines the need for a comprehensive assessment by an alcohol and drug counsellor. The counsellor then decides if residential treatment is the most effective intervention. What is visible here is that this is not Anne's decision alone, but social relations organizing her course of action. The assessment process is organized by the agency, with limited consultation from other agencies or departments.

Assessment within Addiction Services plays a key role in determining the nature of the problem as well as in preparing a plan for service delivery. Noting the importance of an accurate assessment, the agency representative described the paperwork as a gatekeeper, and was frustrated that almost a dozen different forms needed to be filled out before "we were actually involved in a counselling process where we are engaged in carrying out a treatment." Accreditation of Addiction Services agencies has been advanced as a safeguard to ensure accountability, and the policy statement (Alcohol and Drug Programs, 1987) reads:

> Alcohol and Drug Services will use the services of the Commission on Accreditation of Rehabilitation Facilities (CARF) to survey and accredit all its programs... The participation of all agencies and programs funded by Alcohol and Drug Services in CARF accreditation is required and all will have completed at least their first CARF survey by March 31, 2001 (Policy Number 1.C.b.).

This policy, issued in January, 1996, has resulted in documentary requirements that concentrate a great deal of time and energy to sustain the file management. As the agency representative explains, "you have a lot of clients who don't make it through the initial phases because it is so paperwork intensive," and goes on to state, "because the bottom line is, if you can't account for the work, then it didn't happen." Consequently, while the paperwork is viewed as assurance of

acceptable standards of practice, it does not reveal information about barriers it may create in service delivery both for the professional and for the client. Those barriers suggested here are time management in favour of paper versus people and cost in worker hours to complete administrative requirements rather than provide client service.

It has been noticed by the agency representative that some time may be booked off from appointment time so that paperwork can be completed. This documentary procedure required by funders has been articulated by Ng (1996) who, in analyzing a women's employment service stated, "At times, in order to respond to the demands made by the funding program, the agency had no choice but to close its doors to clients for an afternoon or for a day" (p. 40). What this means is that the work that is being funded is not being done so that describing the work on paper can be completed. This creates a dilemma for the organization because its potential productivity as a service provider to clients decreases, and administrative costs in real terms increase. As a result, the documentation can restrict access to assessment and treatment, when as Anne indicates, there is real pressure to expedite the assessment and treatment process to comply with requirements placed by other professionals.

As I have shown both the measurement and assessment practices guide women's activities in their interaction with professionals. The social relations reveal how organizations determine through measurement documents and practices when women misuse drugs. During these procedures, women must describe their drug use within the acceptable categories on these forms. Through assessment documents and procedures, professionals determine if and how women who use drugs receive agency services, reinforcing power relationships in those institutions, and women must provide proof to professionals of their need for services. Some

services are referred to as treatment, traditionally a term used in the medical field. In the following section, I demonstrate how women do "medical work."

Medical Work: Depression, Paranoia and "Straightening Out"

In this section, I argue that both women and organizations conceptualize drug use as a medical issue. Professional terms like "depression" and "paranoia" are also used in everyday language as though meaning is commonly shared. I demonstrate how women and professionals who talk about drug use using medical terms and how the chemical effects of some drugs may exacerbate feelings such as depression and paranoia. Medical notions like biological predisposition and heredity contribute to how women understand the nature of drug use for themselves and for their children. I also show that professionals in the medical field hold varying positions of authority over those who receive their services.

Conceptualized as a medical issue, drug use is described in terms of addiction, dependency, and pathology and drug use focuses on professional practices in health care. This conceptualization of drug use reflects the traditional models of Chemical Dependency Theory, Symptomatic Theory, and Disease Theory as described in the literature review. Pharmacology and the biological effects of drug and alcohol are key to this construction of women and drug misuse. I examine how Anne uses the term "depression" to describe her experience with drug use.

Depression

In talking about what her daily activities involved just before she quit drinking, Anne describes her life:

> But I'd never leave the house... I was just in depression and I didn't even know it. I would never leave my house. I'd always keep the curtains closed, just the TV on and all the lights off, just like I was hiding...*I didn't know anything about it until I went to the treatment centre and they'd say everything about it.* (my emphasis) ...I didn't even want to live actually. I did want to live but I didn't want to leave my house, I didn't want anyone to see me because I'd think they know what I'm thinking. Just paranoid. And just disgusted in myself about my marriage breaking down and then [my child's] father leaving and I thought I wasn't good enough for anybody.

Anne is very unhappy. While she has very real reasons to feel down, because her partner has left and her marriage has broken down, she has learned at the treatment centre to call this feeling "depression." In the treatment centre, she is exposed to a medical model of meaning making and so she is given the term "depression" to use to describe how she feels. Her experience has been pathologized. While this explanation from the treatment centre may have helped her realize that others have had similar experiences, she is now bearing a label that may come with a complex schema of symptoms, which may or may not be appropriate for her. For example, according to the DSM-III-R (1987), depression varies in degrees of severity, duration and sometimes includes the presence of psychosis (p. 228). Medical diagnoses are performed routinely, and treatment and solutions are applied based on those diagnoses. Often these services are provided by the medical practitioners making those clinical diagnoses or through a referral process to professional colleagues. These terms are shared with "patients."

Addiction Services staff are guided by the Code of Ethics for Alcohol and Drug Service Providers (Alcohol and Drug Programs, 1987), issued in March, 1996, under Principle Two: Professional Competence, Section 2.4:

> Service providers will represent their professional recommendations or opinions accurately in all communications, including client documentation, testimony, and public statements. This includes not using a clinical diagnosis or opinion unless there is a documented assessment, observation or diagnosis to support it (p. 3).

In society, medical terminology is used in common everyday language as though the meaning is shared. A word like "depression" may not imply clinical diagnosis, but an indication of a feeling state. However, when women understand their experience as evidence of a clinical diagnosis, the implications can be dangerous.

Anne decides to consult her doctor because she considers herself to be an outgoing person, and she realized that something was wrong when she would never leave her house. She talks about her experience:

> And I even asked my doctor, "Can you give me some depression pills?" And he said, "Oh, you're too young for that."

As a young woman, Anne has now learned that depression occurs in women who are older than her, and what she has experienced does not require medication. However, her alcohol use acts as a depressant on the central nervous system and her experience of depression may be exacerbated by her alcohol use, the drug she has discovered that provides short term relief from her feelings of depression. In a discussion about depression and anxiety, the Addiction Research Foundation (1996) advises: "the symptoms of primary depression are similar to those of depression brought on by heavy alcohol use" and for women, depression often exists before the alcohol dependence and conversely for men. It has been theorized that depression results from the social context in which women live (p. 18). Anne has lost her partner in a social context where a woman's worth is often determined by her male partner. In this instance, her physician has shifted the responsibility to address her emotional state back to Anne.

In a treatment centre she attended to quit drinking, Anne has been taught by professionals to pathologize her experience and use the medical term "depression" to describe it. Her experience of unhappiness has been deemed unhealthy. Although her marital breakdown may contribute to that unhappiness, her initial understanding of her experience is discounted and a

medical diagnosis is adopted. She learns to seek more medical help, asking for pills and consulting with her doctor, in an effort to regain her health. She has been taught that her drinking is linked to her "depression" and she now uses medical language to describe her experience with drinking. The next discussion focuses on another medical term, paranoia.

Paranoia

Like Anne, near the end of her cocaine career (Scheibe, 1994), Tara describes her experience with the name that she, too, has been given for her condition, paranoia:

> After a while, you didn't trust anybody and you'd be really paranoid. You'd start looking out the window to see if the cops are out there, to see if the neighbours are watching, to see what's going on. It was really a paranoid sort of life. You talk on the phone, you think you're being bugged. The cocaine is really bad. I think it brings out people's worst fears and phobias and stuff like that. You're always thinking about people hiding in your closets and under your bed and in the trees. Like I said, you think you're being bugged and the police are looking for you and for one thing, it's probably a good possibility. Because rivalling drug dealers will rat out on each other, too, to get rid of the competition. So, my typical day would be, I'd get up and I'd start using and the phone would start ringing because people wanted it. Once you started people using the coke, sure you'd give them a little bit, like a ½ gram or a gram, or whatever and they'll be calling you within a ½ hour to an hour because they want more, like within a couple of hours. So the phone would start ringing. My boyfriend would start using, we'd both start using and then we both wouldn't want to leave the house and we wouldn't want people to come there. So it would be a total circle of paranoia.

Tara talks about paranoia on many different levels. On one level, she describes her inability to trust anyone based on the knowledge that her boyfriend is dealing drugs from her home. She feels scrutinized by the police. This is a very real concern because the police are actively looking for drug dealers and a common method in police work is called surveillance, the act of surreptitiously watching someone to observe criminal activity.

She knows that this watching has also been extended by the police who may also be granted permission to "bug" her home or her phone, or to watch from inside by utilizing

electronic devices. She knows that this could be happening and whether it is or not, it creates a fear and directs her actions. Foucault (1979) describes this position of power and its gaze:

> Disciplinary power, on the other hand is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have been seen. Their visibility assures the hold of the power that is exercised over them. It is the fact of being constantly seen, of being able to always be seen, that maintains the disciplined individual in his subjection (p. 187).

The police, in their role of law enforcement, intend to change behaviour, and while surveillance is perceived as merely observation it also acts as social control mechanism whether it is enacted or not. The notion that it is possible, even likely, that she may be seen creates a change in Tara's behaviour and in her thinking about her actions, i.e., paranoia. Yet the word she has learned to use to describe this feeling implies that paranoia originates in her, rather than arising from her social context.

She feels observed by neighbours, for she knows that when people are curious, they watch. When they are suspicious, they watch. Because she is engaged in the drug trade, she internalizes the gaze. She is participating in illegal activity and is doing something wrong. She feels guilty. Others can see her actions which they may find suspicious and so, curious, they watch. It becomes a loop now, because feeling guilty, she acts guilty or she performs acts that direct the gaze at her. As Tara states, she would start looking out the window to see if her neighbours or the police were watching her. The agency representative confirms this as a real possibility. "The RCMP becomes aware of people with problems either through complaints or through their own observations." Her action of constantly looking out the window may draw attention to her. For example, a neighbour may notice this unusual behaviour, become alarmed and notify the authorities.

Another dynamic visible here is that other drug dealers may use the police to legitimize their own territory and target other dealers who may be infringing on their consumer group. In essence, what they are doing is removing the competition. "Ratting out" is the act of giving information to authorities. This originated as prison slang and is regarded as a very derogatory term because it goes against a code of conduct of solidarity that is expected and enforced within the penal system by inmates. So solidly entrenched, this code of conduct is often lived unexamined and unquestioned when people are released from prison and has become a norm in the general population. Consequently, although "ratting out" is frowned upon, it is known to be done by drug dealers. This knowledge increases suspicion of police scrutiny, heightens fear and the experience of paranoia. Other factors may also increase her feelings of paranoia.

As in Anne's experience, Tara's drug of choice may exacerbate her response. Cocaine also induces a chemical response in the body and after repeated use, "euphoria is gradually displaced by restlessness, extreme excitability, insomnia, and paranoia--and eventually hallucinations and delusions. The conditions, clinically identical to amphetamine psychosis and very similar to paranoid schizophrenia, disappear rapidly in most cases after cocaine use is ended" (Addiction Research Foundation, 1996, p. 188). Consequently, the drug apparently induces the psychological and physiological experience that Tara is describing, so both the external and internal environments in which she is living contribute to her perception. Distinguishing between real fears and drug induced fears would be difficult, if not impossible at this time.

So, at the height of not trusting, being paranoid, and in the drug trade, she is now exposed to large numbers of other people who come looking for drugs, people like herself who may also be experiencing symptoms of paranoia. She doesn't want them there but she must have

them as they provide the money for drugs and, frightened, she doesn't want to leave the house. Her telephone now becomes an instrument of the organization of her life, creating the media vital to continue her drug use, but also adding to the fear of discovery by police. She is trapped with her paranoia that continues to escalate. Ironically, it is precisely at this point that she is expected to reach out for help and trust someone else, often a professional.

Although medical terminology is often used by professionals, Tara's excerpt shows how she uses the term "paranoia" as "in common" language in order to describe her experience of cocaine use. She describes how other drug users also use this term. While the circumstances surrounding illegal activity may produce these feelings, she works to move from her material experience and articulate an abstract notion that she can share with others. This results in her conceptualizing her drug use as a medical concept, "paranoia." Consequently, these medical terms are used not only by professionals, but also by others in society. Veronica learns about the implications of her drug use from her doctor and she may choose to pass on what she has learned to others.

"Straightening Out"

When Veronica spoke to her doctor, she learned about her drug use and medical implications, "like my doctor said that I have a very addictive personality and that's why I'm worried about my children. Because I guess you can inherit that, I didn't know that. You can get that from your family... ." Her experience with drug use has been pathologized and she fears that she is biologically predisposed to drug use. Her fears are not for herself, rather for her children and their future drug use problems. Should they develop problems with drug use, Veronica will likely blame herself and her predecessors as she has been directed to do by her

doctor. As I have previously suggested, this is another example of how a particular understanding about drug use gets circulated to shape others' ideas.

Similarly, withdrawal from drugs is often conceptualized as a medical symptom of drug misuse, described as an illness here by Veronica:

> I didn't like to be sick, like in the morning and that, it was so awful. And I thought, "Well, there's no way I could stop this now because how bad is it going to get? How much worse is it going to get?"...the fear of being sick... and it's very painful. They say cocaine is all up here (indicates her head), right, when you get sick, this is the craving. Heroin is a physical sick. People go into convulsions from withdrawal from heroin. You've got cramps all over really, really bad. You're puking. You can't keep nothing down. Your bones ache and that's supposed to....even the little bones in your toes ache. Every little bone you've got just aches. You're freezing but your whole body is just soaked with sweat. It's just awful. It's horrible.

Veronica has been taught that these symptoms describe illness and she has no words to differentiate between the symptoms of withdrawal and the symptoms of disease. She described how she uses less of the drug to straighten out, to be normal, "So I wouldn't be high, it was called being 'straightened out'. ...I always used to call it being normal. ...That one little poke took away the pain." As a result, she would use heroin to keep from getting sick and to be normal. In our society, this also describes how doctors use medication, to restore health, or to return us to our "normal" selves and to take away pain. This notion of medicating is further explored by Tara.

Eventually, Tara turned to her doctor for help with her drug use and he prescribed anti-depressants. The doctor was aware of the drugs that she was taking and the anti-depressants produced what she calls, "a flatline, you're not happy, you're not sad, you end up in a medium mode." Questioning the authority of a medical practitioner, Tara tries to look at the difference between licit and illicit drug use, from her standpoint in her everyday physical world. She notes

the similarities between her drug use and using drugs under her doctor's care. She is still taking drugs and her body responds to these drugs as well:

> I said, what's the difference between you and me? You're legally prescribing drugs, so I basically called him a drug dealer...And he was not impressed. To me at that time that's what it was. I'm self medicating and you're medicating for me. Your medication is approved by whoever, but is it really doing me any good? And I don't think it really was. I wanted to get off those and he didn't want me to because that was his way to make sure that he saw me on a regular basis.

She challenges the usefulness of the medication for her. She wonders if prescribing medication serves an ulterior motive for her doctor to monitor her behaviour, to ensure that her life is organized in such a way that she must continue to see him on a regular basis. In looking at who benefits from this arrangement, Tara is uncertain that she is benefiting, but she knows that her doctor gets paid by her medical coverage for each office visit that she attends and the pharmaceutical company also benefits from her purchase of its medication. She gives us a vision of a parallel which is often hidden because this type of drug use is endorsed by the medical relations of ruling and is taken for granted as being beneficial use.

The medical model has traditionally formed the foundation for most alcohol and drug misuse programs. Treatment centres are often located in hospital-based settings with medically-trained staff who work in conjunction with counsellors, social workers, and lay people who are in recovery themselves, people who have "been there" and have subsequently obtained training to work in the alcohol and drug field. Consequently, there are varying levels of expertise and training. Those with training in the medical model such as doctors and psychiatrists are commonly granted more authority and given more prestige, as that academic knowledge has been granted more status and credibility in our society. This passage illustrates what happens when Tara challenges the doctor's role and the suitability of prescribed medication, she knows by his behaviour that he is offended by her challenge. For many women, the physician is the

unquestioned authority on their health issues. Most women are attended by male doctors and most doctors are male. Many women discount their own knowledge about their bodies and the effects of prescribed medication and do not ask questions of authority figures. They trust their doctors. To exacerbate this situation, it is commonly understood that some doctors in the North "fire" their noncompliant patients.

I have demonstrated that when women work to describe their drug use using medical concepts, this leads them to medical solutions to stop using drugs. Women seek help from health professionals. Medical solutions also come in the form of medication to "straighten out" or to withdraw from drugs. As I have shown, some women are prescribed medication as an alternative to their self medicating behaviour. Because women are less likely to challenge the authority of a health professional, they are more likely to comply with medical advice.

Notions like "depression" and "paranoia" are commonly associated with mental health and, as I have found in the review of the literature, women are more likely to attend mental health programs rather than alcohol treatment programs (Weisner, Greenfield & Room cited in Roberts & Ogborne, 1999, p. 54). I have shown how women discount their own experience, especially when they use medical terms to describe their drug use. Professionals and others conceptualize drug use as a medical issue, particularly when words do not exist to talk about drug specific feelings and experiences of women. As a result, when women's drug use is viewed as a medical concept, the position of the health care system is entrenched as a credible authority on women's health, while women's own experience is discounted. This reinforces the relations of ruling and medical concepts become practices of power. The nature of concepts as practices of power is further explored in the next segment on "social skills work."

Social Skills Work: Coping

In this section, I make the argument that women do "social skills work" to describe their drug-using experiences. This conceptualization mirrors the traditional models of Social Theory and Learning Theory. Women have learned that drug use can be conceptualized as a coping mechanism or a way to deal with, or to withdraw from, problems. I show how this concept shapes the practices of institutions that work with women in a specific circular way that justifies institutional practices.

Coping

The women I interviewed talked about drinking and drug use as a way to cope:

> I used drugs and alcohol as a coping tool, as a stress relief. ...When I lapse into drug and alcohol major abuse or misuse is when I have trauma in my life. I went through a period of alcohol abuse where I overused alcohol. Then I started doing blackouts and I didn't like that so I quit that. ...[Cocaine] allowed me to cope. It allowed me to function more and it brought me up out of the depression. It gave me some self-esteem... (Tara).

> To me, my drug and alcohol period was just blanking out, blotting out everything in my life that didn't work, that was painful and ugly and that didn't work (Cathy).

> That's the main purpose, is to stay high so that you don't have to deal with what is going on in your life. ...I might also use the drugs so that I won't have to deal with those feelings (Shanna).

Drinking and drug use have been portrayed by counsellors and other professionals as a coping mechanism that allows women to adapt to life situations and resultant feelings of low self-esteem.[7] The representative from the RCMP also conceptualizes alcohol and drug use as a coping mechanism:

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[7]Self-esteem, a professional label, is defined in Barker's (1999) social work dictionary as "an individual's sense of personal worth that is derived more from inner thoughts and values than from praise and recognition from others" (p. 432).

> The whole prostitution issue...is founded on child abuse that leads to drug abuse. Once the cycle gets started, the young girls...get into drugs in order to cope. They start with the drugs and alcohol as a coping mechanism. Once they have the habit, they have to get out on the streets to earn the money to buy the drug... Drugs and alcohol is the most famous coping mechanism there is for so many people.

Lack of social skills training is identified by professionals. According to this professional, this modelling is usually provided but these young women have not had backgrounds where this training could take place:

> In addition the girls are from backgrounds where they haven't necessarily developed social skills to an acceptable level, definitely no life skills, you know, work skills. A lot of them have dropped out but it's because of their background. I don't want to come across in saying that they are blameless and society is responsible for everything, and there are those who would disagree with me, but I believe the child abuse, the fact that other people are the enablers to keep this going is a huge factor.

Consequently the way women were brought up or educated within families has been targeted as faulty. What this demands from women who use drugs is an understanding that they do not have the skills they require to live effectively and they need to receive education and training for new skill development. Reinforcing feelings of inadequacy leading to low self-esteem, it also means that they would need to participate in further counselling sessions or similar professional services to ensure that those skills were developed.

When professionals assess a woman who uses drugs as lacking social skills, and her drug use is viewed as a coping mechanism, they assume that she has not learned effective tools and that training will help her. For a woman who has lived all her life in poverty, has experienced sexual abuse as a child, and has received and believed many negative messages about herself from family, friends, and society throughout her life, the many coping strategies that she has used throughout her life have been dismissed. Similarly, while "background" and "trauma" and so on are noticed, the target for change is alcohol and drugs.

To elaborate, in my experience as a counsellor, when a woman talks about childhood sexual abuse, she has tried many coping mechanisms, like sleeping with her clothes on, sleeping with the lights on, sleeping with other siblings, sleeping under the bed, pretending to be asleep, mentally leaving the situation, crying, screaming, saying no, telling others, and so on. Yet somehow assumptions are made that she has no coping skills. Because her creative attempts may have been ineffectual against sexual assault by someone likely more powerful both in strength and authority, often in a position of trust, she is informed that there is something wrong with her and she blames herself, blame often reinforced by people in her social sphere. As a child, she believed these opinions about her, and now she is told by professionals that some things are wrong with her, some things that she needs to fix with their help. These are conceptualized as low self-esteem, no coping mechanisms, and no social skills.

What coping mechanisms can she now learn that would have helped her deal with her sexual abuse when she was a child? How is it that professionals advise her that she must now learn new ways to cope with current living situations that are often filled with fear, lack of safety and support, particularly when few resources are available to affect change, poverty promotes a hopeless malaise, and crises happen daily that consume her energy and will to survive? For a woman who now sees her life of desperation replicated in her children, this climate is a catalyst for drug use. However, only drug use is viewed as the "problem" professionally and institutionally.

This illustrates what Smith (1990a) has termed "an ideological circle," where "The categories structuring data collection are already organized by a predetermined schema; the data produced becomes the reality intended by the schema; the schema interprets the data" (p. 93). What I have shown is that because women and drug use is conceptualized in particular ways, the

professional work practice of the organization tends to fix those ways, but it also shapes how those ways are identified, creating a loop of institutional authority that both legitimizes the work being done and also structures the work to be done.

I examined how Smith's ideological circle applies when women do "social skills work" to talk about drug use. In my work, professionals and the documents they use to record their work conceptualize women's drug use as a coping mechanism which is interpreted to mean that women lack coping skills. Therefore, when women who use drugs present themselves for professional help, ways in which these women use drugs as a coping mechanism and lack coping skills are identified by professionals. Professionals then produce ways of working with women to develop coping mechanisms, such as teaching social skills. These practices reinforce their professional work through the common sense thinking that suggests women use drugs as a coping mechanism and they lack skills. Women also come to think about their drug use in ways that can be understood by the organizations that work with them so they can receive services.

Similarly, in her work on the social construction of child neglect, Swift (1995) explains, "child welfare work processes continuously operate to justify the current array of services, which are directed at changing people rather than addressing social ills." She states:

> The argument presented here is not intended to discredit psychological theories, but rather to demonstrate their ideological use in explaining child neglect. The ideological character of the cycle idea depends on making connections between psychological theories and particular cases in a way that suggests that mothers are unable to provide care primarily because they did not receive adequate care from *their* mothers. As these connectives supply us with a satisfactory explanation for poor care, our attention is simultaneously drawn away from the social and economic context in which all these mothers have been doing their work. The cycle idea, in other words, when used to explain neglect, has the effect of reducing social reproduction to a question of psychological problems confined within a large but limited pool of poor families, who are appropriately the focus of the child welfare mandate (p. 99).

In my study, although one of the women links using drugs as a method to cope with her abuse as a child and relates her experiences of violence and oppression, drug use is the identified problem and is interpreted as a lack of social skills that prevent her from leading a more "responsible" life.

I suggest that when drug use is viewed as an individual problem, social skills and employment training become the solutions rather than tackling crippling complex social problems like violence against women and children, poverty and oppression. By holding individual women accountable for drug use, the social relations which foster the social climate in which drug use is necessary to survive untenable situations remain hidden from view. Also it shows how institutions function in creating the work to be done by women. Determining that women lack social skills shapes service delivery; professionals provide those services, and women are taught to see how they need those services and how to see themselves. The social skills that the women identified in their interviews as helpful were "how to socialize again ...how to bring routine into my life, sleeping at regular hours, eating at regular hours," "be[ing] able to control my anger," "just communicating," and "building up that self-esteem."

I have argued here that women conceptualize their drug-using experience as a lack of social skills and their inability to cope with their lives. This concept of women and drug use is revealed by both the criminal justice professional and the alcohol and drug field. Not only do professionals provide information to women about their lack of skills, women also present themselves for help with social skills. This view of the "problem" subordinates concerns about the practicalities of their everyday lives and the social and historical context in which they live. This view of the "problem" proposes that lack of coping skills can be remedied through teaching and training skills because the "problem" is an individual deficit. When social skills are taught

by professionals, this creates an ideological circle. The work of the institutions is justified, and the individual deficit concept of women and drug use is reinforced. Next, I examine how "moral work" is done by women and how this view of themselves impacts their lives and orders their activities.

Moral Work: Stigma, Willpower, Crime, Mothering, and Homemaking

The traditional model of Moral Theory has been overtly rejected as a professional conceptual framework for many years, yet messages about women, drug use, and morality are still prevalent. In looking at drug use as a moral issue, I chose to consider a very broad view of morality that incorporates ideas like stigma, willpower, crime, mothering, and homemaking. I propose that morality is based on polarized ideas of good versus bad, and when women do "moral work" in describing their experiences of drug use, they are met with the taken for granted notion that drug use is bad. The confusion comes when they internalize these ideas about themselves and come to believe, or are told by others, that they are bad, inadequate, or that they are failing to meet standards set for women in our society.

I argue that the "moral work" that women do in talking about their drug use reflects the contradictory nature of expectations created for women in our society; fear of judgment and being judged, issues of power in taking control and powerlessness, commonly held beliefs about criminal implications for women, good versus bad mothering practices, and proper relationships for women to house and home. I show how the dual role of professionals as helpers as well as social control agents add to this confusion and how institutional practices reinforce existing negative stereotypes of women and drug use. I begin by examining how challenging stigma becomes women's "moral work" to prove themselves.

Challenging Stigma

Female drug users were looked down upon in society as bad or immoral, even promiscuous, prior to the inception of the medical model in the 1930s. Consequently these ideas of deviant behaviour have been entrenched in society and appear to shape the way women and drug use is viewed and the way women who use drugs are judged and treated by others. These ideas also shape the way they see themselves:

> So that stigma forces you to hide it, or to pretend longer. ...I found myself in a proving mode in a lot of ways, proving who I am, over-proving who I am, trying to fight that stigma (Tara).

> Our house felt dirty even though it was cleaned really good but there were no needles around, nothing. It was because we were using in that place (Veronica).

Often, stigma drives women to keep their drug use hidden; they fear judgment and condemnation. Consequently, many women are reluctant to get help to quit using drugs because they first must let others know that they use drugs.

In her interview, Cathy states she cannot quit using drugs on her own and describes her thoughts about asking for help from others:

> ...there's so many resources out there, there's so much help and stuff that I'd walk by daily.... People with open arms, and I'd just push them aside. And I don't know what that's about, except the one thing I do know is that these people with open arms and smiling faces and 'we can help you', it was kind of like, because I felt so shitty about myself, it was like it was being rubbed in my face. It's like being around these people that were so holier than thou, these clean sober people, it made me feel worse about myself. So I always gravitated to the people who were as low as me, looked as bad as me, felt as bad as me and then I was comfortable.

Fear of being treated with disrespect and as inferior reinforces how Cathy already sees herself. To reach out for help would mean she would be subjecting herself to the scrutiny of judgment and possible punishment and humiliation, things she has already experienced and internalized. She is influenced by society's belief or myth that all helpers are clean sober people who have

smiling faces and open arms. Accepting these stereotypes, the chasm emerges between these two groups of people. The extremes of these positions illustrates the relations of ruling and preserves the imbalance of power in the social structure of helping services. In challenging stigma, women do "moral work" by first questioning beliefs and stereotypes they hold about themselves and women's drug use in general, and then they do "moral work" to prove themselves to others. Helping professionals may assist in this process using therapeutic relations however, as Cathy suggests, unequal relationships of power and fear of judgment and being judged can act as barriers for women who seek help. Next, I examine the "moral work" of willpower and powerlessness for women who use drugs.

Contradictions--Willpower and Powerlessness

Some women in the interviews said they have been taught they must quit using drugs on their own, without help. I argue that the contradictory nature of loss of control, feelings of powerlessness and willpower creates confusing expectations for women, and constitutes "moral work" for women who use drugs. Some women have learned that quitting drugs demands self control and willpower, an idea pervasive in society. Cathy demonstrates this belief:

> ...I always thought [the addiction] was a moral issue or a self will issue. Like if you are strong enough you can quit. I really, truly believed that.

For women who wish to quit using drugs, personal strength is required to do it by themselves and this comes in the form of will and willpower.

Tara very much valued her independence; she was taught that she must handle things on her own, which is typical of the neo-conservative values of moral behaviour entrenched in her socialization and common in northern communities. In fact she says, "When I was growing up, I was always taught, 'You deal with your problems on your own.' That's how it is. You don't ask

for help. You don't let other people know there is a problem." In fact, she had experienced some success with this approach and she asserts:

> So I'm a very controlled person and I can control a lot of things. Even when I went into the cocaine abuse, I figured, "No problem, I've quit smoking, I've quit alcohol, I've quit smoking pot. No problem. I'm going to go here, see whatever and I just let it go." It was the hardest thing I've ever gone through, was quitting it because it has such a pull on you, such an emotional pull or tie. It's so easy to get lost in that. So it was really hard for me to quit.

Tara knows that she has faced problems with drug use when she was younger and she knows that she has been able to quit using by herself. This affirms what she has been taught, that she can quit using through self-control and implies that just the mere fact of wanting to quit using drugs makes attainment possible. However, she states that she had not counted on the emotional pull that keeps her wanting the drug and its effects. When Tara learned that she would need help to quit and that she could not fight that emotional pull by herself, she was totally unaware of resources, services or how to access help.

In the interview, she described how she turned to her parents to solicit support and not surprisingly, they have no answers to give her because they, too, believe that they must work things out for themselves, and they had not accessed help either. Tara has learned from agencies that work with women and drug use that this is her individual problem, that it is called cocaine abuse rather than cocaine use, and that organizations can help to solve what she has learned to name a "problem." Some organizations require women to admit that they are powerless over drugs, for example those who work using an Alcoholics Anonymous model.

Cathy attended Alcoholics Anonymous meetings and learned a major premise of AA: she must accept her powerlessness over her addiction. This is one of the main tenets of this worldwide self-help group, which originated in the late 1930s (Alcoholics Anonymous, 1939).

She uses this concept as a way to make meaning of her experience. In the interview she describes this powerlessness:

> ...as long as I held on to the idea that I had some control over [drugs], I was doomed. I could not change anything. And much of it was just getting rid of all and any ideas, like how they talk about once you are beaten down to where you know nothing, you know absolutely nothing, then you're teachable.

Consequently, Cathy is being taught that she must accept her powerlessness over drugs which is difficult for her to do given her childhood training to act independently and use her personal willpower. In addition, this concept transfers power to professionals and agencies which can frame a woman's use in very specific and particular ways, ways that lead to services the agency provides. Tara expressed the same experience:

> That was a big thing too, because I was on autopilot, I was just in a mode, I didn't recognize that I was in that bad of an addiction because I could handle it, or I could cope, or I thought I could....Until you give up totally, and you let go. That's when you reach out and you can find yourself and you can reach your God, find your spirituality, find comfort within yourself.

Both these women have applied this learned idea of powerlessness over drugs and feel it has been a beneficial component in understanding their drug use. Women are advised to accept themselves as imperfect and that help comes in the form of a belief in a Higher Power or numinous. The influence of Alcoholics Anonymous' concept of powerlessness is very visible here, and again women's strengths are invisible.

Some women I have worked with struggle to accept the notion of being powerless, particularly when they already feel powerless in the male dominated world in which they live. They may have experienced childhood sexual abuse, rape, abusive relationships, poverty and so on. They know all too well the experience of powerlessness and are struggling to reclaim their own sense of power. This idea of powerlessness goes against the espoused values of self-determination and independence that have been promoted by society as critical to the

development of individual identity, and the professional practices such as those in social work that hold self-determination as a value. The idea of giving up power to gain control over one's life is a paradox. For this reason, some women resist the powerlessness that Alcoholics Anonymous advocates.

Contradictory expectations for women--personal control and powerlessness, and getting help and doing it by yourself--create "moral work" for them. Some women have been taught that the inability to quit drugs on their own represents a loss of personal control, a lack of willpower and resultant feelings of powerlessness. Based on Tara's experience, I suggested that neo-conservative values of individualism and independence (Mullaly, 1997, p. 40) create a barrier for women who want to quit using drugs. This is consistent with the moral conceptualization that seeks to describe women who cannot quit using drugs on their own as deviant or inferior as attested by the prevalence of social stigma that women who use drugs experience, again, "moral work." I now look at women, drug use, and criminal behaviour.

Examining Criminal Behaviour

My argument here is that women describe their drug use as "moral work" and they reveal social relations with the criminal justice system and commonly held beliefs about women and drug use. I suggest that these commonly held beliefs reinforce society's expectations for women's moral behaviour. However, these commonly held beliefs are based on institutionally-based assumptions about women and drug use and these beliefs deny and contradict women's everyday experience.

The women's stories revealed their understanding of the criminal justice system as connected to morality. The following section illustrates this connection. As Shanna articulates

her experience, "as long as I had the money and I could afford the drugs, it wasn't a problem." This brings the social relations into view, as I was faced with the following dilemmas: What constitutes criminal behaviour? Is drug use deemed wrong because it is criminal or because it is immoral? Does it constitute misuse if drug use occurs when not being scrutinized by agencies, or is it only a problem when it is brought to the attention of public authorities? If all drugs were legal and readily available, would the "work" involved in women's drug use change and would the issue of morality be reframed as well? I examine the conceptualization of drug use as a problem later in this section, and I begin by looking at the social relations of criminal activity and what constitutes criminal activity in relation to women and drug use.

Cathy's situation elucidates the social relations of criminal activity to gain money for drugs. Four of the five women I interviewed talked about their participation in criminal activity. For example, Cathy has been involved in shoplifting and stealing solely for the purpose of supporting her drug habit and her partner's drug habit. She explained in the interview that this was a conscious choice she made to protect her partner, and one that would involve the least risk to both of them. Even though the drugs they used are available by prescription, they could not acquire them legally in the quantities they desired. These drugs are not available on request, but rather sold on the street and are expensive. In a black market supply and demand system, drugs obtained illegally cost more. Cathy says:

> Oh, I didn't give a shit any more and I hated [my partner] and [my partner] hated me. That's when I just didn't get it. I didn't...like they say in AA, you're powerless over it. That's exactly what it was, I couldn't quit. Things just got uglier. I was getting caught and I would keep trying to get caught. I tried to get caught doing stupid things, like I'm a relatively intelligent person and I know how to steal and scam and not get caught. But even when I had the baby, I would be doing stupid things and getting caught. Just asking for help, I remember bawling to the officers, "I don't know how to quit. Like I don't know how to quit this."

Many women who use these drugs do not have the economic means to obtain them without resorting to crime. Poverty often accounts for lack of access to resources, training, and education to become gainfully employed, and similarly money is not available to buy drugs. Many are trapped; not enough money to survive and not enough money to escape intolerable conditions through drug use. Even those who initially are able to support the drug habit by working may find they cannot generate enough income to supply their habit or they may have lost their jobs, sometimes due to absences or inability to perform the job due to drug effects.

In this way, both the drug use and the acquisition of money for drugs create difficulties in the lives of these women. Because women earn less than men in the labour market, they are more significantly impacted because of their lower economic status (Addiction Research Foundation, 1996, p. 27). Cathy is aware that as a woman, her income earning capacity is limited. Certainly, she would not be able to earn the $200-$600 a day she requires for herself and her partner to maintain the supply of drugs they now need. She also realizes that she is in an untenable position, she cannot continue and she cannot stop. She can no longer keep committing crimes without being caught. She has come under greater scrutiny by the police and she can no longer get enough money to continue her drug use. She states that getting caught while committing these crimes was the way she chose to get help. Cathy has tried to stop using drugs on her own and made the realization that she cannot quit without help. This is commonly viewed as specific professional help. She sees herself as actively reaching out for help from the police.

While Cathy is aware that there may be serious consequences for her criminal activities that may include charges, court appearances, fines or imprisonment, still she turns to the police for help. The dual role of the police is visible in this situation; one role is that of peacekeeper,

the other is that of law enforcer. She cannot reasonably predict which role they will adopt with her, yet she is willing to take the risk of getting caught in criminal behaviour to receive help to quit using drugs.

Drug use is not illegal, but manufacturing and possessing some drugs, selling drugs, giving drugs to minors and participating in criminal behaviour in order to get drugs or money for drugs are illegal. Also illegal are specific behaviours while intoxicated or under the influence of drugs, such as driving a vehicle or a boat. Creating a public disturbance, negligence, and failing to supply children's necessities of life were cited by the criminal justice professional as sometimes linked with drinking or drug use. In fact, the RCMP representative states, "If you were to remove the drug problem, you'd probably cut theft in half and that's just a general figure." Aware of the larger social context this representative says

> ... but I guess the big thing I want to portray is the police are a short term stopgap. And yes, we can become part of the bigger system and we can be effective within our little niche, but there has to be a bigger operating system before that can come about.

Consequently, it is not drug use per se that is the legal problem, rather acquiring and distributing drugs, and actions taken as a result of drug use are key elements in the conceptualization of drug use as illegal.

Looking at the legislation, the *Criminal Code*, the *Controlled Drug and Substances Act*, the *Canada Evidence Act* and the *Canadian Charter of Rights and Freedoms* apply across Canada and delineate the procedures and penalties regarding trafficking and the more serious drug related offences. The *Liquor Control and Licensing Act* pertains to the provincial liquor laws. Impaired driving and boating fall under the Provincial *Motor Vehicle Act* and impaired driving and boating are also articulated in the *Criminal Code*. This body of legislation explicates what constitutes criminal behaviour in our society directly regarding situations

involving alcohol and drug use. This does not exclude however, other laws pertaining to theft and fraud that may also play a role in ordering the lives of these women. However, the police are trained to look at drug use as a problem.

Problem-Solving

The police categorize Cathy's drug use as a problem. She uses their language:

> [The RCMP would] say..."Well, it's a problem and you should go talk to a drug and alcohol counsellor" and it just seemed so trivial, you know, so trivial. "Go make an appointment to see a drug and alcohol counsellor." Well, I had done that. I had gone the drug and alcohol counselling route, you know? ..."Go to an AA meeting."

Mutual problem solving is one of the principles listed in the RCMP Mission, Vision and Core Values statement and in a discussion following the mandate, it reads, "This philosophy recognizes that the police are integral to society and are not a separate entity and that the main function of policing is problem solving" (Royal Canadian Mounted Police, 1997, appendix). This means that problem solving is a stated fundamental responsibility of the RCMP. Drug-using women are conceptualized as social problems to be solved. For the police, the problem is solved by referring Cathy to an appointment with an alcohol and drug counsellor or sending her to Alcoholics Anonymous. In this way, she becomes someone else's responsibility.

When the police respond to Cathy's situation, they continue to use the problem solving method which compartmentalizes Cathy's life into discrete issues that they can address, while ignoring a more holistic view. Although more comprehensive theoretical approaches are available, the RCMP have been trained to assist in their peacekeeper role by referring those using drugs to community agencies and strengthening their partnership procedure. The current federal RCMP training program is twenty-two weeks long and is based on the problem-solving model, 'CAPR': Client-centred, Acquiring or analyzing information, Partnership with the

community to solve problems in a proactive manner, and Response, which includes the following policing responses: a) protection, b) enforcement, c) service, d) prevention, and e) restorative justice. Consequently, the RCMP act as they have been trained. They conceptualize Cathy's drug use as a problem and refer her to a community partner as they have been directed.

Cathy's poverty is assumed in this situation, and remains hidden and unstated. It is not identified as the problem to be solved. Rather her problem is deemed to be drug use. The police decide they cannot refer her to a private counselling agency, where payment for service is required, so they send her to two resources where services are free: drug and alcohol counsellors whose funding is provided from government coffers, and Alcoholics Anonymous, a self-help group run primarily by volunteers. The police make other assumptions while offering these solutions. As mentioned above, one assumption is that Cathy has no money with which to purchase alcohol and drug services. Another is that she has not sought these services herself already, because if she had, she would not be in the current predicament. They clearly demonstrate the belief that alcohol and drug misuse are problems that can be solved through counselling and through attending self help groups like Alcoholics Anonymous. This shows how drug misuse is conceptualized as Cathy's problem; it is her personal issue. The assumption is that she is personally responsible for having this problem and is also responsible for finding a solution to it. Her private troubles of drug use only become a public issue (Mills, 1959) when she is caught committing crimes by the police who are employed to deter this behaviour. Yet, they immediately turn it back to a private issue by offering services which purport to help people who attempt to give up drugs. They do not appear to examine whether other solutions are possible. Apparently, the police do not know that the proposed solutions may not work and they

do not explore her former attempts at quitting. They remain unaware that she has already tried these two resources and her "problem" has not been resolved.

Getting Help: Services and Referrals

After being referred for counselling at an alcohol and drug agency and to Alcoholics Anonymous by the RCMP, Cathy relates how the alcohol and drug agency works:

> You see [an alcohol and drug counsellor] once a week. Do you know how fucking long a week is in the life of a junkie? That's a humongous amount of time and then you see them for one hour and that's supposed to do you for another week? It's stupid. A week now is not long, a week can go by real quick now, but not then, boy. Every day is so long. "Go see a drug and alcohol counsellor." God! "Go to an AA meeting." Right! Yeah, the problem was just so humongous, I couldn't imagine any little thing working.

Cathy knows that this appointment arrangement is not enough for her, it is too long between counselling sessions without help or support. I can confirm this from my experience as a counsellor in the alcohol and drug field, and after speaking with an alcohol and drug program representative from an outpatient agency. On the one hand, those in the agency know that this system is inadequate and that they cannot respond to the need for more frequent appointments for those newly in recovery. On the other hand, there is a high demand for service coupled with fiscal restraint policies. These contradictory issues prevent the kind of service delivery that, according to the alcohol and drug representative, was "the calibre of service that you might expect fifteen to twenty years ago. It hasn't been that way for a long, long time, especially in the last half dozen years." This representative is referring to service which would adequately respond to Cathy's needs as she gives up using drugs. Those working in the alcohol and drug field know, as Cathy does, that the necessary service delivery cannot be offered or maintained, due to cost cutting measures and priorities for services placed elsewhere. The decision on the

content and form of service provided is made within the agency as dictated by funding sources, namely government and community contracts. In this instance, Cathy and other women are powerless to shape services, to provide themselves with drugs without illegal activity, and to stop using drugs with the help of police and agencies, yet women are held responsible for their own recovery. This absolves the systems of help--the government, counsellor, and police--from having to take responsibility for an imperfect and underfunded system.

This leaves Cathy in a dilemma. She uses drugs which are expensive. She cannot obtain these drugs legally for little or no money. Therefore, her life spirals into shoplifting, loss of her children, self-loathing, and police intervention. Even when she is willing and able to give up drug use, given the many problems in her life, the system of care is inadequate to assist her. In all likelihood, Cathy may see herself as an anomaly. It is commonly believed, as evidenced by the police referral, that if a service exists it must work, at least for most people. Common sense would lead one to believe that a service would not exist unless it actually offers help. Therefore, because the service exists, it is proof that people must be helped there; such common sense could lead Cathy to believe that she is the problem. No one would set up a system that does not work and if it presumably meets everyone else's need, then maybe it is her or maybe she is worse that others. Neither she nor the police and other outside agencies are privy to how the system is operating or to reasons for decision making processes of current addictions services. She only knows that the services being provided have not helped her. It would be easy to see how she might interpret this as a personal failing on her part, when those forces that dictate service delivery are beyond her control and, more importantly, remain invisible to her. She is negatively impacted by those forces.

One example of these forces is revealed when she talks about what time is like for her, and how it has changed in her life. This is significant because it focuses attention on how time is experienced by her now and how time was experienced then. She is trying to sort out the rationale for appointment procedures. In retrospect she is trying to make sense of these practices. She offers a very good account of the rupture between the perception from the agency's point of view and the perception from what she calls the "junkie's" point of view as it relates to time. There is no apparent consideration given to how time is perceived by those in early recovery who require these services. It is clear here that the agency's and the funders' perception of time takes precedence. This, of course, would account for standardized appointment setting, each person getting one hour per week regardless of where they are located in the recovery process. It could be presented as fair and equitable access for service, since all people in Cathy's situation would be treated the same. Hence Cathy does not fit the "standard" image of client that this agency receives funding to assist.

Even after she has tried both Alcoholics Anonymous and an alcohol and drug counsellor, Cathy remains desperate for help. She sees the enormity of drug use in her life. For example, she would catch a glimpse of herself in the mirror and, "it just horrified me. The look on my face, the skinniness of me, just the ugliness. I felt was just wretched." It was so bad she got to the point where she hated to be alone with herself. This conflicts with the above information presented to her as though it is easy to quit, simple to get help. She knows this is not true for her. She feels insulted that her experience has been trivialized. This was revealed in her final statements within this quote, "'Go see a drug and alcohol counsellor.' God! 'Go to an AA meeting.' Right!" said with sarcasm, an indication of her anger and frustration.

This reveals how, as a woman being caught for a crime, Cathy is in no position to state what she knows or what she has experienced because what she says or does lacks authority. She cannot challenge those in authority to examine the veracity of their statements. Consequently, they may assume that she does not really want help, or that she is not ready, or that she is in denial. The RCMP see no need to explore this further with her. Meanwhile as her situation grows more desperate, she continues to try to get help in the only way she knows, by getting caught by the police for her crimes.

In our society, most women still have less access and fewer opportunities to occupy positions of power than men. It is likely that the RCMP officers with whom Cathy is in contact are men, as men constitute the vast majority of positions in law enforcement. This replicates the status quo of the unequal distribution of males occupying dominant roles and positions of authority, and also puts Cathy in a subordinate role on a number of levels; as woman to man, as law breaker to law enforcer, as a person in need to referral agent. She has little or no power in this relationship, she has no authority from which to speak, she can only talk from her experience. In our society unless experience is recognized by the authorities, it remains invalid and is perceived and responded to as a personal trouble to her. Cathy alone cannot possibly correct the misconceptions and she has no support. From her words above, it is apparent that she can present herself in an articulate, intelligent, and capable manner, but in the interaction with police, she is silenced.

Furthermore, the RCMP agency representative disclosed, "... there was absolutely no training except what the laws were concerning drugs." There is no gender differentiation; no distinction is made between men's drug use and women's drug use. Any gender analysis used by a novice member is a result of personal experience or is from a teaching police member in the

field. I contacted the Training Depot in Regina, Saskatchewan and discovered that training around alcohol and drugs is specifically related to law enforcement, rules of evidence and forming partnerships with community groups that deal with alcohol and drug problems. Yet, the lives of women who use drugs are shaped by the police through investigation, arrest, and possible jail terms. In describing how her life was forever changed, Cathy talked about being approached by the police to become an informant:

> Then I started having these officers treat me like a criminal bitch and they were starting to want me to "rat out" on my dealers or find out things. They wanted me to be a "rat" and then they'll lessen my charge. And that really scared me because then I thought, "Oh, my god, I'm a hardened criminal." Like they want me to be a "rat." You see on movies...it's the people that they ask to be a "rat"...oh and I just hated the thought that I'd turned into somebody that they would even think would be like that. That was a horrible realization to me. That really did a lot to make me want to quit.

As Cathy states, when the police tried to bargain with her to reduce penalties, it was the negative movie image of a "rat" as the media stereotype and seeing herself portrayed in that way, that made her more determined to quit using drugs. Veronica also commented on her similar experience, "You know, you're sick in jail, stuff like that. The cops will say, 'If you tell on so and so, I can let you leave. You can go. No charges.'" This pressure to implicate others puts these women in a compromised situation with professionals in authority and demonstrates the imbalance of power in these relationships.

Also in authority are professionals in Addiction Services who use a standardized assessment form called the Drug Abuse Screening Test (Appendix J) to determine drug misuse. Two situations that address illegal activities regarding drug use are indicators used to assess problem severity: "Have you engaged in illegal activities in order to obtain drugs?" and "Have you been arrested for possession of illegal drugs?" Given that these are "yes" or "no" answers, there is no opportunity to provide the context in which any of the given situations occurred.

Help seeking and participating in a treatment program are interpreted as indicators of problem severity in using drugs. This assessment tool determines the nature of problem drug use and prescribes the need for services. These questions serve as benchmarks in defining what constitutes problem drug use from a professional perspective, rather than beginning in women's experience.

Again, while drug use continues to be conceptualized as illegal activity, what is illegal is the criminal activity undertaken to obtain drugs--the buying, selling, manufacturing, and possession of drugs, and some specific impaired behaviour. Notions of criminal behaviour are laden with moral judgments. As illustrated, the actions of the police are viewed as a short term solution until other agencies address women and their drug use. Working in partnership with other agencies and using a referral process emphasizes the individual problem-solving approach rather than looking at systemic issues like poverty and other oppressive forces. The relations of ruling maintain the RCMP as an institution of legislated authority and women who use drugs as subjects of that authority.

I have argued that women do "moral work" in describing their drug use. I examined what constitutes the professionally defined "problem" by looking at moral and legal implications of women and drug use and how this can lead to faulty assumptions. I presented findings that revealed how women's activities are shaped by forces beyond their control, such as, economic and political decision-making of institutions. I also found that many commonly held beliefs about women and drug use advance the notion that this is a private trouble and not a public issue, reinforcing society's expectations for women's moral behaviour. I demonstrated how women's experience can remain unknown when they are in a subordinate position in relation to professionals they come in contact with and when they choose not to challenge commonly held

beliefs that contradict their experience. I suggest that this "moral work" that women do marginalizes their experience and strengthens positions of power of those in authority. In the following section, I examine women's experience as mothers.

"Good" and "Bad" Mothering Practices

I argue that drug-using women do "moral work" when they describe their experience as mothers. I examine expectations of what constitutes good mothering, professional standards for mothers who use drugs, and I demonstrate how assumptions about women and drug use conceal the reality of these women's experience.

Drug-using women's mothering and homemaking practices have often been called into question as moral concerns. Because women are commonly the primary caregivers for children, their drug use may put dependent children at risk. Anne describes her relationship with her social worker and the scrutiny of her parenting practices:

> I'm used to [being checked up on] from the home support because we had supervised visits throughout the four months. I'm used to it. I just can't wait to get my [child] back. ...[The social worker] just drops by whenever she wants. ...I don't have appointments with her. She comes over when she wants to see my [child], see how [my child is] doing. And then, if I go to court I see her.

Anne is aware that her contacts with her child are monitored and information is kept for court purposes. She accepts unannounced visits as a normal event in her everyday activity with her social worker. The circumstances surrounding the removal of her child did involve drinking, but she had made alternate caregiving arrangements that did not happen as anticipated. As a result, Anne's behaviour with her child is scrutinized. I have found, in my experience as a counsellor, that many child protection workers expect women who attend residential treatment for drug use to remain abstinent. Abstinence becomes the easiest baseline to monitor because it is black and

white. Therefore, random urine tests have become routine practice by child protection workers to detect drug use. The decision by social workers to return removed children home often appears to be based on women's ability to maintain sobriety or clean time following completion of a residential treatment program, as witnessed by social workers over the course of a few months. Consequently, professionals monitor women who used drugs.

Expanding the definition of receivers of State services to include women who receive child protection and support services, as well as financial assistance, what Young (1990) identifies as marginalization in our society, fits the experiences women related in my interviews:

> Being a dependent in our society implies being legitimately subject to the often arbitrary and invasive authority of social service providers and other public and private administrators, who enforce rules with which the marginal must comply, and otherwise exercise power over the conditions of their lives... . Dependency in our society thus implies, as it has in all liberal societies, a sufficient warrant to suspend basic rights to privacy, respect, and individual choice (p. 54).

Women who use drugs are marginalized and their lives receive scrutiny through a documentary process which follows them as they are bound to a path of recovery. There exists a tension between role of helper/advocate and role of authority both for the agency representative and for the women with whom they work. Women I see are often confused and angry when they have formed a relationship with the child protection worker (referred to as "my social worker" by participants) and have given them information about themselves in order to receive help. Ironically, they find this same information is used in family court proceedings against them. Betrayed, they are reluctant to share any further information with other people in positions of authority. Because women are fearful that their children will be removed, often drug use is concealed or minimized, both before and after counselling and treatment for drug use. This is Cathy's situation. She loved her child, "I was really happy to be pregnant. I just loved having the baby. When [the baby] came out, I loved being a new mom. I loved everything about it. But

I couldn't get over this addiction." When Cathy brought her baby to the hospital for routine medical attention, her drug use was reported by a friend, and she was confronted by two Ministry for Children and Families social workers. After trying to detoxify herself and relapsing, she was advised that she must give up custody of her new baby or the infant would be removed. She has been judged unable to care for her child due to her drug use and she feels she has no recourse. She internalizes these judgments: "I don't understand this. You know, I've got my baby in one hand and a rig in the other and I choose the rig." This image is a prevalent one. It is as though women believe that there is a conscious struggle between their drug use and their children and if they really loved their children, they would be able to give up using drugs.

Veronica also confirms this line of thinking. When she is asked how she knew that drugs were a problem for her, she admits, "Because I gave my kids away, my kids were really close to me. I chose drugs over them. So I knew it was a big problem then." This myth seems to be perpetuated by the notion that a good mother loves her children above all else and if a woman continues to use drugs, she is not putting her children first. Through its medical and professional practices, society judges that she is unable to care for her child, and she is deemed an inadequate parent. Baker & Carson (1999) elaborate that conventional ideology reveals that "any woman who is not white, middle-class, married, and heterosexual is a bad mother" and they argue, "Substance-abusing mothers have been stigmatized, labelled as unfit, and targeted for disapproval due to their failure to meet cultural standards for mothering" (p. 348). In my research this is revealed as the automatic labelling of women who use drugs. In turn, they label themselves as unfit mothers or inadequate parents whether or not this is the case.

Child protection workers in British Columbia are mandated to protect children, and the BC Handbook for Action on Child Abuse and Neglect (Province of British Columbia, 1998) sets out the following:

> Our responsibility to report child abuse and neglect is backed up in law. The *Child, Family and Community Service Act* requires every person who has a reason to believe that a child has been or is likely to be abused or neglected, or may need protection, to promptly report the matter to a child protection social worker.
>
> Under the *Criminal Code*, physical assault, sexual assault and other sexual offences involving children are crimes, as are abandoning a child and failing to provide the necessities of life (p. 1).

This handbook also provides a detailed protocol for interagency cooperation and outlines the guidelines expected in working together to provide information so that an accurate assessment can be made on each investigation in child protection by the Ministry for Children and Families. Protocols have been developed over the years to ensure information sharing. This is related in Practice Standard #1, "You must follow all protocols for child protection and information sharing with police, health, education and other service agencies and organizations." Practice Standard #2 outlines involvement with aboriginal communities and information sharing protocols (Province of British Columbia, date unknown, p. 7-8). These professionals, in meeting the mandate to protect children, can demand access to information that they deem necessary to assess risk of harm to a child. Therefore, every agency that has contact with parent or child is required to relinquish information and documentation. Without parental consent, critical information can be obtained by child protection workers. In my interview with a Ministry for Children and Families representative, I was informed that one phone call to a provincial database with a Personal Health Number by a child protection worker can elicit a detailed list of the most recent prescriptions purchased by a parent suspected of drug use where there is a child protection concern. Child protection workers have access to school records, medical records,

criminal records and any other information, except protected information such as client/attorney privilege. The *Freedom of Information and Protection of Privacy Act* suspends its powers in cases of risk to a child where child protection workers require information. Agencies share information with one another so that a better and more informed assessment can be made.

The child protection agency representative who I interviewed estimated that half of her caseload have alcohol problems and 35 to 40% have problems with drug use. The agency representative was careful to caution that this does not imply that parenting is affected by their alcohol or drug use in every case. Drug use is not evidence of neglect or poor parenting practices, but may be an indicator of risk. In determining risk in the Ministry for Children and Families Intake Report, several factors are considered. The Risk Assessment (Province of British Columbia, 1996) offers guidelines to explore the family's social history and present circumstances using a deficit based model. Because the Risk Assessment (Appendix K) is a checklist format, there are standardized codes that categorize information. Standardized coding is used to quantify women's experience and objectifies particular instances of women's everyday lives. In seeking to regulate information, details are often excluded or ignored, favouring a specific understanding or view of circumstances. Women's experience must fit a predetermined mold that is shaped by the organization and directs the work of the organization, rather than creating space for how women wish to present their everyday world.

In Risk Factors (Appendix L), in the area of Alcohol or Drug Use and Parental Influence (second item in first column), the following categories and their numerical designation are offered:

4.) Substance use with severe social/behavioural consequences,
3.) Substance use with serious social/behavioural consequences,
2.) Occasional substance use with negative effects on behaviour,
1.) Occasional substance use,

0.) No misuse of alcohol or use of drugs, and
9.) Insufficient information available (p. 68).

There is a strong influence here to quantify highly subjective and unique circumstances. While coding procedures are further explicated in *The Risk Assessment Model for Child Protection in British Columbia* (Province of British Columbia, 1996), there is no recognition of periods of sobriety or the nature of drug use, information that fits outside the frame established by the agency. The segment under category four states, "Drug dependence may be indicated by: suspected sales and/or manufacture of drugs; abandoning social responsibilities (e.g., unemployed, spouse has left, child is abandoned); or severe behavioural problems (extreme aggression or passivity, no concern for future, confusion much of the time)" (p. 41). It is assumed that these characteristics indicate drug use, but these characteristics are also indicative of other problems like racism, poverty, oppression, and feelings of despondency. Categories such as the latter are not conceived by the agency as significant information and do not find room in the institutional account of the risk assessment.

In looking at risk reduction, it would be impossible to change one's upbringing which is a factor in the risk assessment, and there is no process in the assessment that shows new understanding of family issues. The family of origin is assumed to play a key role in parenting skills now, but again this does not account for intervention by significant others or for other forms of learning parenting ideas. It does not take into account that deficits in parenting abilities may result from lack of resources rather than lack of knowledge. The risk assessment does not acknowledge the impact of poverty, racism or other forms of oppression, but merely identifies individual deficits as factors in assessing the care of children, illustrating an institutional account that tells only what it asks.

My research revealed that women consistently placed their children with relatives when they thought their drug use no longer allowed them to provide the standard of care they wanted for their children. In my opinion, this shows a very strong bond between mother and child and indicates that she does put the needs of the child first. In contrast to the prevalent view of women who use drugs as neglectful or bad mothers, I would argue that compassion and ensuring that adequate care is provided are qualities of good mothering.

Again, a teaching tool used extensively in the alcohol and drug field to describe the nature of abusive relationships, the Minnesota Model of the Power and Control Wheel, indicates that a partner may use the term "unfit mother" as a threat to keep the woman in the relationship or to gain custody of the children. This indicates a very common concern for mothers who use drugs. They see themselves as failing to provide adequately for their children and certainly the label of "unfit" mother in legal matters holds great weight. When the mother does not comply with her partner's demands, legal action may be invoked. Tragically, sometimes these women are also convinced that somehow they are not good enough mothers and they may not challenge these assumptions regardless of their competency in mothering practices.

Many women identify drug use as the reason for losing custody of their children. When women have their children removed or lose them through a legal process, they often blame themselves, give up hope, and use more drugs. Tara describes her understanding this way, "...the other [child] I lost through drug and alcohol addiction, but I've recently got [my child] back," and through tears she said:

> My child means a lot to me and I think if it was just me, I wouldn't have bothered to come out [of using drugs], I would have just stayed there. ...So for me to go through the loss of my child without that crutch was really hard for me to do and to learn how to deal with issues.

She, like the other women I interviewed, has been taught that drug use is her problem and that she must live without drugs in order to parent her child.

I have shown how mothers who wish to quit using drugs face a moral dilemma when they seek help from professionals and fear removal of the children due to the risks of drug use. I have argued that this "moral work" that women do when they describe their drug-using experiences as mothers increases scrutiny by professionals in their lives, both by monitoring behaviour and through a documentary process eliciting information from other professionals and from family and friends. I have shown that standards for mothering practices of drug-using women often require abstinence, not expected as a standard in the larger population, and that risk assessment practices can fail to validate alternative models of effective mothering. I also reveal how confusion arises when professionals perform the dual role of helper and authority.

I suggest that because women who use drugs do not conform to society's expectations for mothers, assumptions are made that drug-using women are "bad" mothers, reinforcing negative stereotypes. This message is internalized and women label themselves as "unfit" or "bad" mothers creating "moral work" for drug-using women. This moral conceptualization of mothers and drug use fails to acknowledge their experience of providing good parenting to their children and creates an artificial dichotomy of good versus bad mothering. What follows is an examination of women's role in the home as partners and as homemakers.

Homemaking and Relationships with Partners

I argue that women's morality is associated with their homemaking and with their relationships with partners. Expectations for behaviour require drug-using women to do "moral work" when describing their experience. For many women who use drugs, homemaking was

considered women's work and they sought to fulfill these demands. Relationships with partners reveal taken for granted assumptions about what women are required to do both in the home and in the relationship. I suggest that this moral concept about women and drug use shapes their thinking and organizes their behaviour. Anne talks about her experience:

> We'd probably get up, hungover, wait till 9:00 for the beer store to open and go there and get a sixpack or something, start drinking, clean the house, eat, and just stay home and drink. Near the end that's all I did was just stay home. ...Yeah, I did all my house duties.

Cleaning the house is important for Anne. The house has become both a haven and a prison for her. After the breakdown of her marriage, she doesn't want to be seen by anyone. She is hiding. Society and her partner have given her a message that she has failed somehow and she has internalized that message and attempts to withdraw from the world. She does so by staying home, but she also does so by drinking. When she was drinking, Anne says, "I could just forget it, turn the lights on once in a while." Her home environment is shaped by how she feels about herself, as though it is an extension of who she is. She has learned as a woman that what she looks like and what her home looks like reflect who she is and is an external expression of how she is feeling internally. Because women are given expectations that the home is their responsibility, these messages are directed toward women. This could mean that if a woman is not cleaning her house, or if she is not attractive, then there is something wrong with her or something wrong with how she is feeling. Other demands were made on these women as well.

Many of the women I interviewed supported their partner's drug habit as well as their own. This has been documented in the research literature and reveals that maintaining their partner's habit has been a barrier to women's success in recovery (Amaro & Hardy-Fanta, 1995). Partners continuing to use drugs will actively sabotage a woman's attempts for recovery because they fear not only the possible loss of the relationship, but also the loss of the means to get

drugs, or money to buy drugs. The women did different work to get this money; one worked primarily as a prostitute, and one worked at stealing and shoplifting to exchange merchandise for cash. Another woman worked in the business sector and thus provided a home for her boyfriend who eventually moved in with her and used it as a site from which to sell drugs. One woman provided money for drugs for herself and her partner because, "I wouldn't let him do the work that he was used to doing to get the drugs. So it was my responsibility to get it... ."

For Shanna, who worked as a prostitute, initially there were some legal considerations that placed her partner at greater risk if he were caught in criminal activity to get money for drugs, but there were other reasons too:

> ...it was just kind of the attitude, his attitude was, "Well, it's easier for you to go and work the streets than it is for whatever," and it was just kind of expected. It wasn't so much verbally said but you definitely got the message that it was up to you to supply the drugs and take care of the kids and do whatever, right?

What she understands from her partner in the relationship is that it is her role to supply the money for drugs as well as take care of the children and look after the home. She is also given these messages in our society where home and family matters are the woman's responsibility. But in this situation, she is also seen as the breadwinner for the purchase of drugs for herself and her partner, yet he still occupies the dominant role in the relationship. In the interview she talked about the burden of making enough money, "I mean, God, sometimes we were spending $3000 a month...and I swear if we had more we would have spent more." She also described how age was now becoming a factor in being able to continue to earn this money when there were so many other prostitutes who were younger and on the street, and youth is valued and seen as more desirable in our society.

These messages from her partner are implicit. This, too, is consistent with the literature that examines women's role in the home, and the invisible nature of women's work described in

depth by DeVault (1991) and Baines, Evans, & Neysmith (1991). At face value it may be assumed that this was Shanna's choice; she didn't know for sure because it was never overtly stated, it was taken for granted. However, this point of view discounts her understanding of the context within which she is living. She understands her role has been shaped by societal expectations of women and she complies. Her partner shares her assumption, and does not demonstrate an alternative plan through his own actions. In fact, he is complicit in the prostitution and actively enables her in that work.

She describes the nature of the relationship with her partner after they had separated and he applied for custody of their child stating that she was an unfit mother because of her drug abuse and prostitution:

> ...it really bothered me having papers saying that I was an unfit mother because of prostitution and drug abuse because it was OK for [several] years as long as he was benefiting from it...I remember when him and I were both doing drugs, I'd get a phone call at 2:00 in the morning and he'd go out and sleep in the car, lay down in the car in the driveway and I would turn a date in our bedroom...But it was allowable because he needed the drugs as much as I did. He needed the money as much as I did, and then suddenly, it's being used against me? I mean, that still really irks me.

His role in her prostitution remains unexamined by the court. While she can be declared an unfit mother, his role as a parent is unquestioned. Because the court system promotes an adversarial relationship between the parties, it is expected that she will "deliver the goods" on him, provide the evidence to support her case, her accusations. However, in this situation, it is apparent that it would be to her disadvantage to give information about his former drug use, his previous history of living off the avails of prostitution which could be used against him now in assessing his parental ability, just as these concepts are being used exclusively to judge her. It is apparent that this is directed solely at the female partner and her parenting ability is being determined by her previous lifestyle, a lifestyle that they shared. She at least knows that this man will allow her

access to her child. If they were both ruled unfit parents, the State could assume the role of parent and she would have no control over access.

She sees this action by her partner as manipulative and largely unfair to her. Her work was condoned when it met his needs for drugs but now that she is in recovery she bears the burden of it and he takes no responsibility for it. As the representative from the RCMP stated:

> Certainly in the prostitution trade, there are hangers-on around a lot of those girls that are on the street, the women on the street. One unfortunate part is that once mom is on the street and there is a younger daughter coming up and mom has a drug habit, the kids are raised in a drug and prostitution atmosphere. It is very common for that daughter to end up on the street as well. Now the money that she makes, if mom doesn't make enough, goes to support mom's habit or boyfriend's habit, whoever that is, or dad's habit. It's an area that I'd love to have the resources to get into from an enforcement point of view; going after the people that are really living off the avails of prostitution which is a far more serious offence than prostitution itself, or than communication for the purpose of prostitution. But that is a very common dynamic within a family once they have reached the point where mom is a working prostitute.

According to this representative, the police are aware of male partners living off the avails of prostitution, yet the lack of resources and decisions regarding priorities in prosecution keep them from investigating further, even though, as is stated, it is the more serious offence. This awareness also remains hidden from the women, and they are open to interpret the lack of police response in many ways; prostitution may be seen as more reprehensible, or that what they know to be criminal behaviour by men is condoned and the police choose not to investigate or prosecute these men.

But as this police representative also says, "When prostitution enters a residential area you get a strong backlash from the public. For the most part it's aimed only at the prostitutes when in fact the prostitutes are only the visible part of the whole prostitution cycle." The police are more likely to respond to public outcry by targeting the prostitute. Recently a new protocol in Prince George has been created to target the "johns" who use a prostitute's services but the

outcome is still unknown. The drug pushers are also named by the law enforcement representative as playing a large role in enabling prostitution. It is apparent to the police that while prostitutes may be the most easily identifiable part of this cycle, more resources are needed to enforce these more serious offences, such as living off the avails of prostitution.

I have argued that women perform "moral work" when they talk about relationships with their partners and their homemaking practices. I have shown how some women are expected to clean house, earn money for drug use, as well as take care of children, and how this is accepted and assumed to be "women's work.." I show some inequities in institutional practices that target women's behaviour and fail to examine men's active participation. Although professionals are aware of this inequity, lack of resources prevent institutions from taking alternate courses of action to correct the situation, and as a result, the uneven practices of power are maintained. The next section is a summary of my findings.

Concepts as Practices and Relations of Ruling

Through agency documentation, I have shown how women do "medical work," "social skills work" and "moral work" to describe their experience with drug use. The everyday experience of women has been edited from the institutional account as categories and definitions shape how documents are filled out and read and transform their story to fit the format required by the organization. Concepts become practices of organization and shape the nature of work for both professionals and women. This institutional ordering of work reveals ruling practices that organize the lives of women who are attempting to clean up.

Through my interviews and analysis, I argued that women work to describe their drug use using medical, social skills, and moral concepts, and how those concepts determine and are

determined by the work of institutions. I revealed how the concept of illegal drug use describes some behaviour involved in drug use, but that drug use, in and of itself, is not illegal. I suggest that the stories of women's lives have been reduced, minimized, and marginalized to conform to the institutional account. I also described how the relations of ruling are reinforced by the practices of institutions and how the conceptualization of women and drug use as an individual problem instructs women to assume responsibility and fails to address issues of social context and social responsibility. If drug misuse is understood as an individual problem only, then treatment and therapy become instruments of social control which reinforce the status quo and maintain the power imbalance. Waldegrave, in an interview with Law (1994) explains:

> If you have a problem that is associated with something external, something structural in society, and you end up having your problem sorted out in therapy, you then go away believing that you were the author and creator of your problem, and that's an untruth. It perpetuates the powerlessness, the inadequacy and the lack of self-determination of whole groups of people (p. 22).

Because professionals have conceptualized drug misuse as an individual problem, in acknowledging the social context in which drug use occurs and when social factors like racism, sexism, and oppression are explored, professionals primarily address these factors by identifying how those racist, sexist, and oppressive messages about one's self have been internalized at the individual level, turning them back into private troubles.

Inequity is built into law enforcement as I have demonstrated when women are targets for prosecution in the prostitution trade. In the court system, women are labelled as "unfit mothers" while their male counterparts do not receive the same designation, i.e., "unfit fathers."

The final chapter articulates the conclusions that I have drawn from my study, with implications for social work practice and social policy. I explore possibilities for further research and how my understanding about women and drug use was transformed.

CHAPTER FOUR: CONCLUSIONS

In examining the social organization of women and drug use, I have illustrated how women describe their everyday experience of drug using that is understood by others, particularly those in institutions. Concepts shape and are shaped by "in common" understanding and become crystallized as discrete entities defining women and drug use. Through ideas about alcohol and drugs, women's experiences have been abstracted and taken out of their everyday material context. I illustrate how women did "medical work", "social skills work," and "moral work" in talking about their experience with drug use. My research demonstrated how these concepts about drug use do not fully describe women's experience and that knowledge about women and drug use is limited by these conceptual frames.

Consequently, when I examine the phrase "I'm here for me," I understand that women have been taught that this is an acceptable way to enter into treatment services from professionals. The phrase indicates their motivation and investment in the treatment process. Women have been taught that they must talk about putting their needs first in order to access treatment services, which contradicts traditional expectations for women. Many women have been shaped by expectations for women that put the needs of family and home first before their own. This phrase then places personal responsibility solely on her and reduces the need for professionals to look at other external pressures in her social context.

I found that the language of professional discourse tends to take common, everyday words and turn them into terms of illness or pathology, like drug misuse. Women assume this conceptual frame so they are eligible to receive services as they identify their drug misuse, seek help and meet the criteria. This research shows that documents shape how information is conceptualized. In this way, much of women's experience is carved away and is shaped to fit the

mold constructed and required by the institution to justify the mandate and purpose of the organization. This practice also legitimizes the authority of the institution. I have revealed how these women's activities are "ordered, managed, *ruled*–to support *interests that are not their own*" (Campbell & Manicom, 1995, p. 12).

Economically, institutions initially profit from sales of alcohol and attached fees for licencing and similar services. Because women have less power in society and less influence in ruling practices, they have very little control over the power structure, yet their work in identifying alcohol and drug use as an individual problem supports and maintains the existing structures that oppress them. As ruling practices, concepts now define women's experience with drug use in particular ways, which determines and is determined by courses of actions set out by the state in service delivery to women who use drugs. Since women lack the authority granted to institutions by society, they are marginalized and silenced. Consequently, what they know about their experiences with drug use, when not fitting the institutional norm, may be assumed, unsolicited, and silenced. As a result of my interviews with women, with professionals and, in examining the documents related to professional work, I found that when drug use is conceptualized as a problem for individual women, the actual living conditions that serve to create the environment in which drug use provides an escape are rendered invisible. Institutions have the power to define women who use drugs using concepts, concepts that are revealed in the interviews and documents, and concepts can be "prised apart" (Manicom, 1988) to discover the ruling relations.

As I have demonstrated, the state organizes work to regulate drug use. Alcohol distribution is facilitated by state agencies designed to generate revenue and deter sales to

minors. Legislation is in place articulating procedures and penalties, such as fines, licence suspension, and imprisonment for drug related offences.

The state, by funding alcohol and drug agencies, also works to regulate alcohol and drug use. By delegating responsibility to alcohol and drug counsellors, work is directed to help individuals stop using drugs. While individuals are encouraged to adopt traditional models that identify drug-using behaviour as personal attributes requiring change or additional learning, not addressed by these agencies is the environment that encourages drug use. When the social context is examined, however, responsibility is placed back on the individual to change personal circumstances. Women are more vulnerable to these circumstances; since they have less earning power in society, they have fewer economic resources to facilitate change.

Women and drug use is conceptualized in many diverse and sometimes contradictory ways. The BioPsychoSocialSpiritual theory, currently in use in British Columbia, is one attempt to merge traditional and current concepts about women and drug use. While more inclusive as a conceptual framework, this theory still targets individual responsibility for use and quitting use. The institutional form does not recognize the need for change at a collective level. While poverty, racism, violence, and oppression are significant factors in many women's lives, these are not addressed on a collective level by these agencies. In fact, the judicial system routinely supports inequitable treatment of women.

Other organizations are also recruited into regulating alcohol and drug use. In this study, I examined the professional use of power to see how concepts that have official authoritative bases come to also organize women's thinking about themselves. Professionals organize drug-using women's activities through a partnership and referral process to alcohol and drug agencies, as well as other self-help organizations. The RCMP also deter drug use through criminalization

of behaviour involved in drug use: the manufacturing, acquisition, possessing, selling, and distribution of drugs as well as behaviour while intoxicated. When women who use drugs are identified as a public issue, they are seen and treated as individuals with private troubles. Again, institutional practices demonstrate the assumption that responsibility for drug use resides with individuals and they are directed to agencies which use individual strategies to promote change within the individual.

Recommendations

Research provides valuable information that can strengthen professional practices. Taking the findings from this research, I show how this new information is useful personally and professionally. In the following section, I also reveal areas of further study that would provide more information about women and drug use.

Implications for Social Work Practice

Institutional ethnography as a method of inquiry provides a way to hear the stories of women and demonstrate how their lives are shaped and ordered. The women in this study hold a key position as subjects of their experience. In sharing that experience, I was able to see how information about women and drug use was conceptualized and used as though it was "in common" to all. Those concepts, many based on traditional theories of drug use grounded in research with men, serve as ruling practices that exclude and marginalize women's experiences of drug use and quitting drug use, as well as aspects of their lives which may foster drug use.

Although institutional ethnography has its roots in sociology, it is very appropriate as a

method of inquiry for social workers and can be used to raise awareness of how drug use is organized beyond women's experience:

> Viewing this collective project as institutional ethnography allows us to specify what was formerly sketchy, to identify areas where more work is needed, and to develop a more exacting knowledge of the social relations determining women's everyday worlds. We increase thus our capacity as sociologists to disclose to women involved in the educational process how matters come about as they do in their experience and to provide methods of making their working experience accountable to themselves and other women rather than to the ruling apparatus of which institutions are a part (Smith, 1987, p. 178).

In advocating accountability to other women, institutional ethnography also advances feminist principles. Through accountability to other women, I anticipate that women working together in a collective way may assist in challenging theories about women and drug use that do not fit and that address the gap between their everyday experience and concepts about women and drug use.

While some consideration has been given to community interventions with the creation of drug misuse prevention programs promoted by the RCMP and Addiction Services, few opportunities exist within these institutional structures to address issues like poverty, racism, and other forms of oppression on a systemic rather than an individual level. I have noticed as a social worker that this work is often done as unpaid voluntary service and is often done collectively with other agency representatives who likewise find that structural change is not promoted within the organizations that employ them. More attention to social context and environmental concerns that address women and drug use as public issues may promote strategies on a collective level, that might be more conducive to change. Among professionals and in society generally, it appears that current concepts about women and drug use remain assumed, unexamined, and unchallenged.

Social work education that promotes critical thinking about women and drug use and looks at how models of service delivery are created and maintained is very important here.

While social work students receive education about organizational structures, social workers may find that the institutions that employ them do not have systems in place to support collective action at the macro level. I think that Smith provides some inroads into these questions by looking at concepts as ruling practices. Smith (1987) describes institutional ethnography and anticipates how it can be best utilized:

> The approach I have tried to develop is above all conscious that we are not doing a science that can be treated in abstraction from the rest of society (indeed the possibility of such a science is a myth). Our intellectual work and the ways in which we can make a society conscious of itself are very much a part of that society and situated in institutional context we did not make, though we are working to be part of their remaking (p. 9).

How to enhance change processes in the social context and how to promote systemic change within these institutions are, I believe, essential studies for social workers, particularly in academic institutions modelling receptivity to critique and systemic change within their own organization.

Implications for Social Policy

Drug use is regulated by institutions. In society, rules about recreational drug use have relaxed and are being challenged through legal courses of action. This means that misuse can no longer be abstinence-driven as more of the population use drugs on a social level. Institutions whose concepts about women and drug use are based on old and limited research sustain and uphold a societal norm that has come into question. This creates a tension between agencies who act as social control agents and the women whose drug use they are employed to control. Because women's experience has been marginalized or silenced, they lack the authority granted to organizations and they cannot challenge these notions. Documentation as social relations shapes what information is required and shapes the work of the institution. The challenge to

provide institutional accountability without coding, categorizing, and conceptualizing women and drug use is daunting, if not impossible.

In addition, fiscal restraint policies in "lean" times present a lack of resources in all state agency arenas. Midgley (1995) describes the relationship:

> For example, if the economy experiences recession, the revenues needed to fund the social services decline and the fiscal pressures on governments increase. Similarly, the need for social services is likely to be higher during times of economic adversity when more people need assistance and when government revenues are generally lower (p. 24).

During my interviews with government agency representatives, each one spoke of cutbacks and how this impacts their work and, in particular, limits their ability to provide effective service. Again, practices focused on individual responsibility for change. Issues like poverty, racism, violence, and oppression are not addressed on a collective level. The neo-conservative agenda advances an individualistic approach to self-determination and capitalism encourages independent action and creates strategies that promote personal responsibility. This climate is conducive to the institutional practices that I have found in concepts about women and drug use. Social policy can be reformulated to conceptualize collective action that targets social forces as the work of the state, particularly in front line work by professionals.

Further Research

The area of women and drug use is both fascinating and challenging as a topic of study. I also found that the women I interviewed had a unique relationship with the medical profession. Although I chose not to concentrate on this particular institution as a focal point for this inquiry, I think it would result in findings which increase our understanding of power relations.

In doing the research for this work, I noticed that I had looked at research that originated in Canada and the United States, and thus, how women and drug use is conceptualized is framed

within a North American context. I would like to conduct this same research in the United Kingdom to see how conceptual practices differ in a another context. Sweden, Australia or other sites for inquiry would also be interesting as their legislation may reveal different concepts of women and drug use and different ruling practices.

Transformative Elements

My own work with women who use drugs has been significantly impacted by this study. This research enabled me to identify how concepts have shaped my understanding and the understanding of the women with whom I work. In my counselling practice, I had previously thought that teaching theories of drug use and their history would be helpful as a tool to see how this problem with drug use is viewed by others, offering a recognition and encouraging an understanding of opposing and contradictory views. I feel I have been co-opted in recruiting women into theories that not only offer little to describe their lived experience but also validate knowledge that increases the gap between what they experience and how it is conceptualized. I know clearly that I participate in ruling practices and that I, as a professional, am granted much authority in society and in the institutions in which I have been employed.

As I heard more about the everyday lives of women and drug use in my role as researcher, some of it was a surprise for me. In my practice as a counsellor, I had simply not inquired enough to see the impact of legal processes in their lives. I was unaware of the large role that law enforcement played in the lives of the women I worked with and I saw drug use in a new way. In my professional practice working in a residential treatment centre, I saw a sanitized and safe version of the lives of these women. In working with these women, I too sought

individual strategies for individual problems, even after hearing countless stories of the effects of poverty, racism, violence, and oppression.

My biggest discovery was how hard it was for me to see my own language practices and how, despite my best intentions, I continue to use words that pathologize and professionalize different terms, taking them out of everyday language and creating social constructions. I am disillusioned by the documents which became perfunctory for me, that marginalized women and their experience. I had always been so aware of confidentiality, worried about telling too much, that I was blind to practices of omission, those pre-scripted stories of women that did not represent them adequately or accurately.

I present these women as subjects whose descriptions of their everyday activities are shaped by professionals like me. I also recognize that in my role as researcher, I also participate in practices of ruling. I edit and select which part of the story to tell, what is important, and I have a unique vantage point to view the inquiry. Being able to do this study is a privilege, but it is also a responsibility. I am not only accountable to the academic process for this inquiry, which requires its own concepts as practices and directs my work, but I am accountable to the women who trusted me with their experiences as well. My life has been enriched personally and professionally in my work with these women.

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Appendix A–Signed Consents for Research

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UNBC

UNBC Ethics Committee

October 21, 1999

Ms. Barb Keith
2379 Shearer Cres.
Prince George, BC V2N 3B7

Proposal: 19990917.98

Dear Ms. Keith:

Thank you for submitting the revisions to your proposal entitled, "Cleaning Up: The Social Organization of Women and Drug Misuse".

Your proposal has been approved and you may proceed with your research.

If you have any questions, please feel free to contact me.

Sincerely,

D. Kemp

Alex Michalos

BRITISH COLUMBIA

October 25, 1999

Barb Keith
c/o Nechako Treatment Centre
2000 – 15TH Avenue
Prince George BC V2M 1S2

Dear Barb;

I have reviewed your summary of your thesis proposal and support you in this endeavour. I would recommend that you peruse section 1.D.1 – Adult Addiction Services of the Program Standards – Alcohol and Drug Services Manual.

I wish you every success in your study.

Sincerely,

KMcNeil for:

Peter Cunningham
Community Services Manager
Northern Interior/ Northern Region

:km

Ministry for Children and Families
Northern Regional Office
402 - 1011 Fourth Avenue
Prince George BC V2L 3H9
Telephone: (250) 565-4387
Facsimile: (250) 565-4427

Prince George Regional Hospital

October 14, 1999

Ms. Barb Keith
C/o Prince George Regional Hospital
Nechako Treatment Centre
2000 – 15th Avenue
Prince George, BC
V2M 1S2

Dear Ms. Keith:

Re: Research Study Titled
Cleaning Up: The Social Organization of Women and Drug Misuse

This letter will confirm that the Prince George Regional Hospital, Research Review Committee in their meeting of October 5th, 1999 approved the above noted study as presented.

Should you have any questions or concerns in regards to implementing the study or concerns throughout your study, please do not hesitate to contact me.

Upon completion of your current study we ask that you provide the Committee a written notification when the study has concluded, including an anticipated time frame in which you will be available to present your findings, within one year of completion.

Wishing you every success.

Sincerely yours,

Ian Sehlokking MD
Chair,
RESEARCH REVIEW COMMITTEE

IS/bb

Prince George Regional Hospital Medical Staff
2000 – Fifteenth Avenue, Prince George, BC V2M 1S2
Phone: (250) 565-2506 Fax: (250) 565-2343

Appendix B–Letter of Informed Consent for Women

CLEANING UP: THE SOCIAL ORGANIZATION OF WOMEN AND DRUG MISUSE

Letter of Informed Consent

I am willing to talk about my experiences with alcohol and/or drugs and my understanding about alcohol and drug misuse. I am willing to be interviewed by Barb Keith, a Master of Social Work student at the University of Northern British Columbia under the following conditions:

1. I know that my participation is completely voluntary and that I may withdraw at anytime. I can stop the interview at any time. I also know that I can view the transcript of my interview and verify the accuracy of the information. I know that the interview may take up to three hours and I may need to commit an additional hour of my time to verify the accuracy of the transcript. I also know that Barb Keith plans to contact representatives/agencies that I discuss in my interview with her.
2. I understand that no names or other identifying information will be included in the transcripts or in the final thesis report. I am aware, however, that some descriptions about incidents in my life may appear familiar to those who know me, but that every precaution will be taken to protect my identity. Other potential risks may include recalling unpleasant memories of my experience with alcohol and drugs and discovering how organizations may have impacted or shaped my life in negative ways. Potential benefits may include having my experience validated and valued and know that by sharing I may contribute to a greater understanding of women and drug misuse.
3. The consent forms, the transcripts, the taped interviews and any other personal information will be kept in a locked file drawer with access only by Barb Keith. I understand that this will be stored for a period of two years. At that time all personal information and recordings will be destroyed.
4. I understand that lengthy quotations may be used from the interview, but that names will not be used. Barb Keith may use this information in her thesis, presentations, or other publications. I know I can get a copy of the final thesis from Barb Keith if I wish.
5. I understand that information regarding child abuse or a child whose safety is at risk will be reported to the appropriate authorities in accordance with the legislation of the Province of British Columbia.
6. If I have any questions about my participation in this research project I know I can contact Barb Keith at 563-4783. I can also contact her thesis supervisor, Dr. Barbara Herringer at 960-6643. I am aware that any complaints about this research project should be directed to the Office of Research and Graduate Studies at the University of Northern British Columbia at 960-5820.

I understand the above conditions and I give my consent to having my information used in this manner. I am willing to participate in the interview as part of the research process.

_____ _____

Signature of Research Participant Date

_____ _____

Signature of Researcher Date

Appendix C–Letter of Informed Consent for Agency Professionals

CLEANING UP: THE SOCIAL ORGANIZATION OF WOMEN AND DRUG MISUSE

Letter of Informed Consent

I am willing to talk about the policies, legislation, practices and documents that my agency uses in working with women and drug misuse. I am willing to be interviewed by Barb Keith, a Master of Social Work student at the University of Northern British Columbia under the following conditions:

1. I know that my participation is completely voluntary and that I may withdraw at any time. I can stop the interview at any time. I also know that I can view the transcript of my interview and verify the accuracy of the information. I know that the interview may take up to three hours and I may need to commit an additional hour of my time to verify the accuracy of the transcript.
2. I am aware that details obtained from my interview and from agency documents will be analysed and documented in the final thesis report. Potential risks may include discovering gaps in service delivery to women who misuse drugs. Potential benefits may include discovering what is currently effective in service delivery as well as gaining feedback from users of our services.
3. I have followed all protocols within my agency regarding my participation in this research project.
4. The consent forms, the transcripts, the taped interviews and any other personal information will be kept in a locked file drawer with access only by Barb Keith. I understand that this will be stored for a period of two years. At that time all personal information and recordings will be destroyed.
5. I understand that lengthy quotations may be used from the interview, but that specific names of agency professionals will not be used. Barb Keith may use interview and textual information in her thesis, presentations, or other publications. I know I can get a copy of the final thesis from Barb Keith upon request.
6. If I have any questions about my participation in this research project I know I can contact Barb Keith at 563-4783. I can also contact her thesis supervisor, Dr. Barbara Herringer at 960-6643. I am aware that any complaints about this research project should be directed to the Office of Research and Graduate Studies at the University of Northern British Columbia at 960-5820.

I understand the above conditions and I give my consent to having my information used in this manner. I am willing to participate in the interview as part of the research process.

Signature of Agency Professional	Date
Signature of Researcher	Date

Appendix D–Information Sheet for Women

CLEANING UP:
HOW DO WOMEN KNOW
THEY HAVE A PROBLEM WITH ALCOHOL AND DRUGS?

Would you like to be part of a research project that examines women's knowledge about alcohol and drug problems?

I am a Master of Social Work student at the University of Northern British Columbia and I have worked as a therapist with women and drug misuse. I am interested in figuring out how women know they have a problem with alcohol and/or drugs.

The purpose of this research is:

1. To look at women's experience with alcohol and/or drug misuse.
2. To better understand how women come to believe alcohol and/or drug misuse is a problem for them.
3. To study the role of society in shaping our understanding about women and alcohol and drug misuse.

In the fall of 1999, I will be conducting interviews (1-1/2 to 3 hours each) with women who:

1. Have identified alcohol and/or drugs as a problem in their lives.
2. Who are currently in recovery.
3. Wish to understand more about women and alcohol and drug misuse in society.

If you find this topic interesting and would like to learn more, please contact Barb Keith for more details at 563-4783 during the evening or on weekends.

Thank you,
Barb Keith, Researcher

Appendix E–Interview Guide for Women

CLEANING UP:
THE SOCIAL ORGANIZATION OF WOMEN AND DRUG MISUSE

Interview Guide for Women

How did alcohol and/or drugs affect your life? Tell me how alcohol and/or drugs was a problem for you.

-can you describe a typical day that involved your using alcohol and/or drugs and tell me about your activities?

What did you know about alcohol and/or drug problems at that time?

Once you decided that alcohol/drugs were a problem for you, what did you do?

-how did you know what to do?

-did this change the way you saw yourself?

Describe what you did to get help. How did you find it?

Probe: previous history, resource knowledge

Tell me about the kind of help you received.

Probe: was this help effective?

Probe: was there any help that you anticipated getting but did not find?

What is your understanding about using alcohol and/or drugs now?

-has anything changed?

-if so, what changed and why do you think that changed?

Appendix F--Information Sheet for Agency Professionals

CLEANING UP:
THE SOCIAL ORGANIZATION OF WOMEN AND DRUG MISUSE

Information Sheet for Agency Professionals

I am a Master of Social Work student at the University of Northern British Columbia and I have worked as a therapist with women and drug misuse. I am interested in figuring out how women know they have a problem with alcohol and/or drugs.

The purpose of this research is:

1. To look at women's experience with alcohol and/or drug misuse.
2. To better understand how women come to believe alcohol and/or drug misuse is a problem for them.
3. To study the role of society in shaping our understanding about women and alcohol and drug misuse.

I will be conducting interviews with women who have experience with alcohol and/or drug misuse, for a description of how drug misuse affected their lives. I will be asking how they sought help. These interviews will then be transcribed. Professionals from those agencies revealed in the women's transcripts will be interviewed about their policies and practices in working with women and drug misuse. I will be requesting copies of agency documentation for a textual account of how the work with these women is organized within the institution. I would like to find out how this work is then carried out through specific professional practices with women.

I anticipate that audiotaped interviews with agency professionals would be between 1 to 3 hours in length. If you require any further information about this study, please contact me at 563-4783.

Thank you,

Barb Keith, Researcher

Appendix G--Interview Guide for Agency Professionals

CLEANING UP:
THE SOCIAL ORGANIZATION OF WOMEN AND DRUG MISUSE

Interview Guide for Agency Professionals

How do you know a woman misuses drugs? How do you make that professional decision?

-what tells you that this is an area of work?

How do you work with women and drug misuse?

-specific theoretical framework
-approaches/models specified by the agency

What are the specific practices performed by agency professionals in working with women and drug misuse? What activities are undertaken?

What documents are used by your agency that guide your work?

-copies of documentation used in working with women and drug misuse
-copies of policies, practice standards
-copies of legislation

Appendix H–Addiction Services AIMS--Outcome Measures

BRITISH COLUMBIA Ministry for Children and Families — Addiction Services

ADDICTIONS INFORMATION MANAGEMENT SYSTEM OUTCOME MEASURES

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Freedom of Information and Protection of Privacy Act*. Under certain circumstances, the collected information may be subject to disclosure as per the *Freedom of Information and Protection of Privacy Act*. Any questions about the collection, use or disclosure of this information should be directed to the Director, Addiction Services Branch, (250) 952-0113, PO Box 9717, Stn Prov Govt, Victoria, B.C. V8W 9E1.

☐ CLIENT INFORMED

OFFICE IDENTIFICATION

Program Type	Agency Code	Office Code

CLIENT IDENTIFICATION

Personal Health Number	Last Name (First initial only, if PHN given)	Given Name	Gender

Date of Birth (YYYY MMM DD)	INTAKE DATE (YYYY MMM DD)	DISCHARGE DATE (YYYY MMM DD)	FOLLOW-UP DATE (YYYY MMM DD)

EFFECTIVENESS - *Rate using scale below*

1 - Excellent *3 - Fair* *N/A - Unable to contact Client*
2 - Good *4 - Poor*

	INTAKE	DISCHARGE	FOLLOW-UP
Physical Health			
Emotional/Mental Health			
Employment/Vocational/ Educational Status			
Social Condition			
Criminal Justice Involvement			
Significant Relationship Conditions			
Housing Conditions			
Service Outcome			
Satisfaction with Service			

SUMMARY DATA (Complete when client leaves program) (YYYY MMM DD)

Assessment Completed ☐	Date	
TOTAL NUMBER OF SESSIONS:		
Individual		
Group		
Family		
Medical		
Off Site		

ALCOHOL USE

Age of First Use	INTAKE		DISCHARGE		FOLLOW-UP	
	Excessive Days	Moderate Days	Excessive Days	Moderate Days	Excessive Days	Moderate Days

OTHER DRUG MISUSE

Drug Type	Age of First Use	Intake Days Using	Discharge Days Using	Follow-up Days using

GAMBLING ACTIVITY

Gambling Activity	Age of First Time	Intake Amount	Intake # of Days	Discharge Amount	Discharge # of Days	Follow-up Amount	Follow-up # of Days
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	
		$		$		$	

MCF913(05/11) DISTRIBUTION: ORIGINAL - CLIENT FILE COPY - TO CENTRAL OFFICE WHEN COMPLETE

Appendix I–Ministry of Attorney General Application for Special Occasion Licence

BRITISH COLUMBIA Ministry of Attorney General Liquor Control and Licensing Branch

The information provided on this application will be a part of the Special Occasion Licence, if issued. Please ensure that the information provided is accurate and complete. This information is collected under the authority of the Liquor Control and Licensing Act (RSBC 1979 c. 237). The information provided will be used to process an application for a Special Occasion Licence and may be shared with representatives of the Liquor Distribution Branch, the Liquor Control and Licensing Branch, police agencies, and local governments. It may also be released to other parties upon request. If you have any questions about the collection and use of this information, contact the Liquor Control & Licensing Branch at 2nd Floor, 1019 Wharf Street, Victoria, B.C. V8W 9J8, Telephone: (250) 387-1254

APPLICATION FOR SPECIAL OCCASION LICENCE

PERSONAL INFORMATION

NAME _____ PHONE NUMBER _____

HOME ADDRESS _____

CITY _____ POSTAL CODE _____

YOUR "SERVICE IT RIGHT" CERTIFICATE NUMBER _____

ORGANIZATION INFORMATION

NAME OF ORGANIZATION _____

ADDRESS OF ORGANIZATION _____

CITY _____ POSTAL CODE _____

TYPE OF SPECIAL OCCASION LICENCE APPLYING FOR

☐ FAMILY EVENT $10 ☐ PRIVATE EVENT $10 ☐ PUBLIC EVENT $40 ☐ MANUFACTURER PROMOTION/RESEARCH

DESCRIPTION OF EVENT: _____

EVENT DETAILS (shaded areas for store use only)

	LOCATION OF EVENT	ADDRESS	DESIGNATED AREA WHERE LIQUOR WILL BE CONSUMED
1			
2			

	DATE OF EVENT	APPROX # OF ATTENDEES	TIME OF EVENT FROM	TO	FEE (INCL. PST)	LICENCE NO.
1						
2						

LIQUOR QUANTITIES AND PRICES*

LIQUOR	QUANTITY	PRICE
Spirits		$ per oz.
Packaged Cooler/Cider		$ per bottle/can
Draught Cider		$ per 12 oz. glass
Packaged Beer		$ per bottle/can
Draught Beer		$ per 12 oz. glass
Wine		$ per bottle
Wine		$ per 4 oz. glass

** Subject to Liquor Price Schedule Maximums*

LDB STORE MANAGER'S COMMENTS

STORE NAME _____ STORE # _____

MGR _____ PH # _____

POLICE COMMENTS/ENDORSEMENT

DECLARATION: I hereby make application for a Special Occasion Licence under section 6 of the *Liquor Control and Licensing Act* to purchase for consumption at the time(s), date(s) and place as set out above. I am qualified to purchase liquor pursuant to the *Government Liquor Control and Licensing Act* and I have read and understand the regulations printed on the reverse of this form. I understand that any person who makes a false statement when applying for a licence, commits an offence.

U-BREW, U-VIN AND HOMEMADE WINES OR BEERS ARE NOT PERMITTED AT THIS EVENT

SIGNATURE _____ DATE _____

Attach the original application to the licence(s) when issued. This application and the licence(s) must be prominently displayed during the event.

WHITE: APPLICANT *PINK: LDB STORE MANAGER* *CANARY: POLICE*

AA050 (01/98) 7532841508

Province of British Columbia

SPECIAL OCCASION LICENCE
SECTION 6
LIQUOR CONTROL AND LICENSING ACT

WARNING

The applicant should be aware that by Section 6 (1) of the Liquor Control and Licensing Act, a Special Occasion Licence is issued only for the function named in the licence and subject to its terms and those contained in the Act and Regulations. Furthermore, by Section 71, 73 and 74 of the Act, if there is a breach of the Special Occasion Licence, the Act or Regulations, a peace officer may seize all liquor which could subsequently be forfeited to the Crown.

IT IS TO YOUR BENEFIT TO UNDERSTAND THE PROVISIONS OF THE LICENCE AND THE APPROPRIATE PARTS OF THE ACT AND REGULATIONS, INCLUDING THOSE NOTED BELOW.

THE LICENCE IS TO BE PROMINENTLY DISPLAYED FOR THE DURATION OF THE EVENT.

The following regulations apply to the licence:

(1) The fee for a special occasion licence is: Private Functions – $10.00; Public Functions – $40.00.

(2) The general manager shall prescribe how frequently a special occasion licence may be issued to any applicant and also the number of days and hours for which the licence will be in effect.

(3) Any person issuing a licence shall endorse on the face of the licence the retail price at which liquor may be sold and, except in the case of charitable events, the retail price of drinks served will be set so as to recover only the operational costs.

(4) Notwithstanding section 42 of the Act, minors may enter or be upon a licensed establishment when a special occasion licence is in effect.

(5) The local police authority or a person designated by the general manager shall approve any application for a special occasion licence prior to issuance.

(6) Where a special occasion licence is approved by a person designated by the general manager who is not a member of the local police authority then the person issuing the special occasion licence shall, prior to the event to which it relates, inform the local police authority of the nature, time and place of the event.

(7) All liquor that is sold and consumed under a special occasion licence shall be sold and consumed in the licensed establishment or that part of the licensed establishment indicated on the licence.

(8) No person shall advertise or promote the special occasion by indicating that liquor will be sold or served.

(9) If a special occasion for which a special occasion licence is to be issued is to be celebrated on lands or premises owned or operated by a municipal or regional authority or by the Provincial or Federal Government, the applicant must, prior to issuance of the licence, produce written permission for the event signed by an authorized public official of the municipality, regional authority, Provincial or Federal Government on whose land the event is to take place.

(10) The licensed establishment in which liquor is sold and consumed must be enclosed and all means of access supervised to the satisfaction of the local police authority.

(11) Where a special occasion licence is issued to a private organization for a non charitable event, no person shall be admitted except members and guests of the organization.

(12) A person issuing a special occasion licence under this section shall provide the licensee with a copy of these regulations.

(13) When a special occasion licence has been cancelled pursuant to section 20 and 24 of the Act, the licence shall be surrendered forthwith to the general manager or a person he may designate.

LOB-48888 P.O. 77514 02/93

What else do I need to know?

- When your SOL is issued, the Provincial Sales Tax (PST) of 10 per cent must be pre-paid on projected revenue generated through the sale of beverage alcohol products. If your event is cancelled, or you make a PST overpayment, you may claim a refund from the Consumer Taxation Branch, Ministry of Finance and Corporate Relations. Call (250) 387-0654 for details.
- Police and liquor inspectors have the right to enter and inspect the premises while your event is in progress.
- Gambling is not permitted in the licensed area.
- The maximum number of SOLs granted to any person or bona fide organization is generally two per month, or 24 per year.
- SOLs are not issued for events that are intended to make a profit, unless the Liquor Control and Licensing Branch is satisfied that the purpose of the special occasion is to raise funds for a bona fide charitable purpose.
- **A restocking charge of 10 per cent will be applied where the retail value of product returned exceeds $200 (excluding taxes).** Proof of purchase will be required and returned product must be fit for resale, i.e. packages sealed, labels intact, full cases of beer or cider and no evidence of mishandling.

For more information, visit your local BC Liquor Store, or check out our Web site at **www.bcliquorstores.com** (click on "Service Matters," then "Special Occasion Licences"). Or, contact the Licensing Clerk, Special Occasion Licences, at the Liquor Control and Licensing Branch:

2nd Floor, 1019 Wharf Street, Victoria, B.C. V8W 2Y9

Phone: (250) 387-1254
Web: www.ag.gov.bc.ca/lclb/special.htm

Special Occasion Licences are regulated by the Liquor Control and Licensing Branch, Ministry of Attorney General, and administered by the Liquor Distribution Branch.

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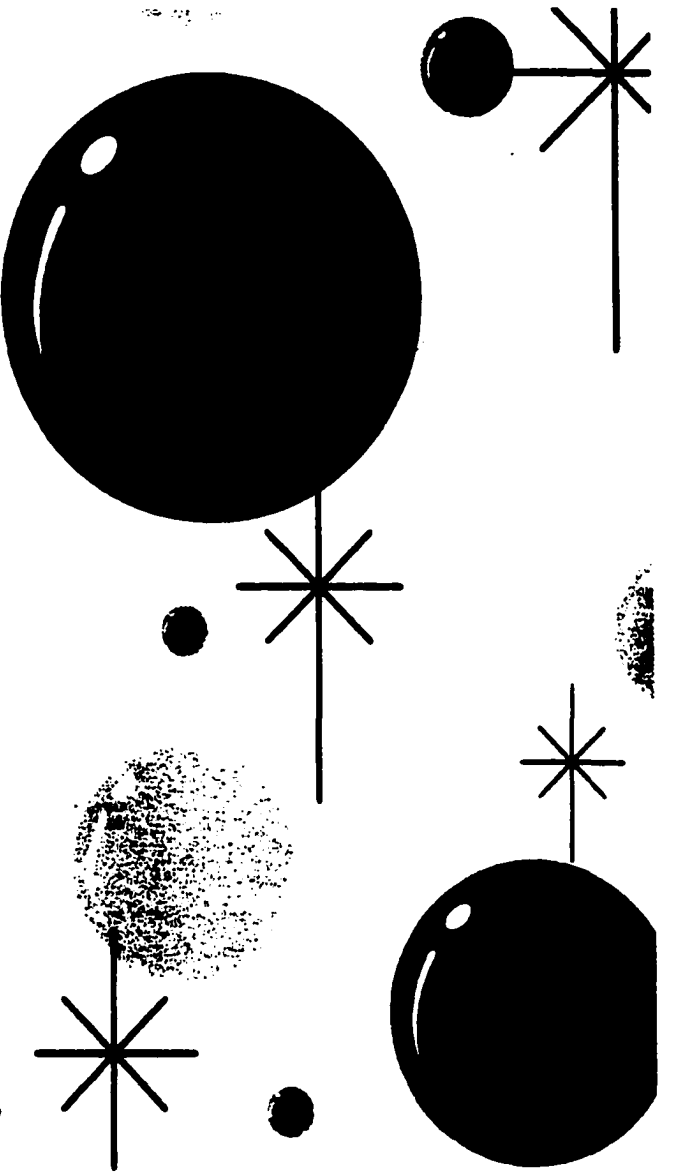

Special Occasion Licences

Planning to serve or sell alcoholic beverages at a special event?
This brochure outlines your responsibilities when hosting a family, private or public event where beverage alcohol will be consumed, served or sold.

BRITISH COLUMBIA **Ministry of Attorney General**
Liquor Control and Licensing Branch

What is a Special Occasion Licence?
A Special Occasion Licence (SOL) is a licence issued for not-for-profit, special occasions such as weddings, banquets, club functions and community festivals where alcoholic beverages will be served or sold. Special occasions are not events which are scheduled on a regular basis.

Do I need a licence?
If you or your organization plan to serve alcoholic beverages at an event in a public place (e.g. any place, other than a personal residence, that could draw the attention of the public), or sell alcoholic beverages at an event held in any location, you need a SOL.

What kind of licence do I need?
There are three types of SOLs: family, private and public. Note: fees are subject to change.

Family

This licence is for special family events such as weddings, christenings, birthdays or anniversaries, hosted by a family in an unlicensed public facility. (Note: Wedding "stags" are not family events.)

- Family events held in a residence do not normally require a licence. (Note: It is illegal to sell alcoholic beverages in a residence unless you are licensed to do so.)
- All types of alcoholic beverages may be provided or sold in accordance with the maximum liquor price schedule.
- For family events, SOL holders are not required to take the *Serving It Right* (SIR) training program. If a manager is used at the event (paid or unpaid), they must complete the SIR licensee or server training program; paid servers must complete the SIR server training program.
- The licence fee is $10 per day.

Private

This licence is for special events held by organizations that meet regularly for a common purpose, be it for social, cultural, recreational, religious, sport or community reasons.

- Attendance is limited to the organization members, staff, invited guests or persons who purchased advance tickets. All tickets must be sold before the event begins. (Note: The event begins when the doors open.)
- The SOL applicant may be required to produce satisfactory proof that the organization is genuine.
- Private events may be subject to local police approval. Ask the local BC Liquor Store manager for details.
- The SOL applicant must complete the SIR licensee training program (cost: $48).
- Managers (paid or unpaid) and paid servers must complete either the SIR licensee or SIR server training program. Cost of the server program is $28.
- SIR licensee certification requires that the certificate holder be in attendance at all times during the function. The licensee may delegate this responsibility to a manager (paid or unpaid), or a bona fide member of the organization, provided that person also holds a SIR licensee certificate.
- All types of alcoholic beverages may be provided or sold in accordance with the maximum liquor price schedule.
- If the event is intended to raise money for a charity, the SOL holder may apply to the SOL Clerk, Liquor Control and Licensing Branch, to exceed the maximum liquor price schedule.
- There should be an adequate variety and supply of food and non-alcoholic or de-alcoholized beverages available.
- The licence fee is $15 per day.

Public

This licence is for community events or public celebrations that may require local government and police approval.

- Public events may require the approval of a Committee to Approve Public Events (CAPE) if one exists in the municipality or regional district where the event will be held.

- The SOL applicant must complete the SIR licensee training program (cost: $48).
- Managers (paid or unpaid) and paid servers must complete either the SIR licensee or SIR server training program. Cost of the server program is $28.
- SIR licensee certification requires that the certificate holder be in attendance at all times during the function. The licensee may delegate this responsibility to a manager (paid or unpaid), or a bona fide member of the organization, provided that person also holds a SIR licensee certificate.
- There should be an adequate variety and supply of food and non-alcoholic or de-alcoholized products available.
- Distilled spirits, other than spirit-based coolers, are not generally permitted, unless approved by the police and local government.
- Beer, wine, cider, and coolers may be provided or sold in accordance with the maximum liquor price schedule.
- If the primary purpose of the event is to raise money for a charity, the SOL holder may apply to the SOL Clerk, Liquor Control and Licensing Branch, to exceed the maximum liquor price schedule.
- The licence fee is $60 per day.

Do I need a licence for my company office party?
A licence is not required for a legitimate office party provided all of the following conditions are met:

- Alcoholic beverages are not sold.
- The event is closed to the public and takes place in the office space normally occupied by the business hosting the event.
- Attendance is by advance invitation only and is limited to the employer, employees and invited guests.
- The office party cannot draw the attention of, or be visible to, the general public in any way. If noise or the location of the event will draw public attention, a licence is required.
- No fee is charged for entry, entertainment or services (e.g. fees for mix, ice or glasses).
- The business is not a liquor licensee (e.g. a restaurant, pub, etc.).

For more information, contact the Licensing Clerk for Special Occasion Licences, Liquor Control and Licensing Branch, at (250) 387-1254.

Who can apply for a licence?
A club, group of people, organization or society may apply for a licence for an event at which alcoholic beverages will be served, consumed or sold. A family member may apply for a licence for a bona fide family event such as a wedding reception or anniversary party that will take place in a public facility. In most cases, only B.C. residents who are a minimum of 19 years of age can apply for a licence. Non-residents should contact the Licensing Clerk for Special Occasion Licences at (250) 387-1254.

Can a caterer apply for and hold a licence on behalf of a client?
No. Only genuine members of an organization, society, or family hosting the event can apply.

Where do I apply for a licence and how much does it cost?
You can apply for a SOL at any BC Liquor Store. The procedure varies depending on the type of event planned. In most cases, a *Serving It Right* certificate will be required (see below).

Do I need to take the *Serving It Right* program?
With the exception of family events, the person to whom a SOL is issued must successfully complete the *Serving It Right* (SIR) licensee training program at a cost of $48. The program is intended to make people aware of their responsibilities when serving alcoholic beverages to guests or patrons. The SIR course package, available online at **www.hieac.com/training/** or at any BC Liquor Store, includes a correspondence test which must be submitted and marked before a licence is issued. The test can be submitted by mail or fax. For more information, contact the Hospitality Industry Education Advisory Committee toll-free at 1-800-665-8883. You can also e-mail them at **info@hieac.com**.

What information do I need when I apply for a licence?
When you are ready to apply for your SOL, please bring the following information with you:

- date and address of event (including exact site location)
- number of attendees and event hours
- SIR certificate number (if applicable)
- quantity of alcoholic beverages that will be required
- selling price of alcoholic beverages (if applicable)

Will I need municipal or police approval?
Often you will require written approval from the local government and the local police responsible for the site of the proposed event. The police may add conditions to any licence approval. Please check with your local BC Liquor Store for more details.

After I apply, how long will it take to get my licence?
In some cases it can take up to four weeks or longer to receive your SOL, so apply well in advance. If you require a SIR certificate and plan to submit your SIR application by mail, allow at least four weeks for processing. If you prefer to fax your application, you can submit it, along with VISA or MasterCard payment, to (604) 930-9771. You will receive your SIR certificate number within one day.

May I serve products purchased from a beer and wine store, or serve/sell my homemade beer or wine at my special event?
No, this is prohibited by law. Only products purchased at a BC Liquor Store or an approved agent (such as a rural agency store, on-site winery or on-site cottage brewery) are permitted at the event. Homemade beer and wine, U-brew and U-vin products, and products from beer and wine stores, may not be served at your event.

May I promote drink specials or complimentary cocktails in my promotional material?
No. Advertisements may not indicate in any manner that alcoholic beverages will be available, served or sold at your event.

My child isn't 19 years of age. May she attend the event?
Yes. Minors are permitted as non-drinking patrons or entertainers at most SOL events. However, they are prohibited from consuming, serving or handling beverage alcohol. They are also prohibited from selling drink tickets.

What are my responsibilities as a licence holder?
When you apply for a SOL, you agree to abide by the Liquor Control and Licensing Act and Regulations. The laws which govern commercial licensees, such as prohibiting service to minors and intoxicated persons, also apply to you. You are responsible for complying with the conditions and requirements of the licence you have been issued (listed on the back of the application form), and are responsible for the safety and sobriety of your guests. Additional information on your responsibilities can be found in the SOL application package.

Who should I contact to help me plan a designated driver program?
The Insurance Corporation of B.C. (ICBC) offers materials to help plan your event and ensure a safe ride home for everyone. Materials include posters, table cards, server buttons for volunteers and clip art, so you can include the **"get home safe"** message in your event's publicity material. For more information, contact your local ICBC office.

Appendix J–Addiction Services Drug Abuse Screening Test (DAST)

6.4 The Drug Abuse Screening Test (DAST)

Description: The Drug Abuse Screening Test (DAST) is a measure of problems related to psychoactive drug use. The 20 questions on the DAST are concerned with the client's involvement with drugs only, and not alcoholic beverages. The DAST provides a reliable estimate of drug abuse severity. It can be used to monitor changes in clients over time.

Target Population: The DAST has been designed for use with an adult population. Functional literacy in English is required. Like the MAST, the DAST is to be given to all adult clients regardless of presenting problem and substance use/substance affected or problem gambling/problem gambling affected status.

Administration: The DAST should be administered as a self-report questionnaire, except with clients who have difficulty with reading comprehension. In these circumstances, the DAST may be given in an interview format. Clients are asked to circle either "yes" or "no" in response to the 20 questions. The DAST takes approximately five minutes to complete. The DAST, together with the MAST, should be given to clients at the first formal session with a counsellor. The window of enquiry is the past year.

Scoring and Interpretation: The scoring scheme for the DAST is as follows:

- All "no" responses receive a score of 0, and all "yes" responses receive a score of 1, except for questions 4 and 5, where the scoring is reversed. For questions 4 and 5, a "no" response scores 1 and a "yes" response scores 0.
- Individual item scores are totaled to obtain the DAST score, which may range from 0 to 20.

The total DAST scores reflects the client's severity of problems or consequences related to drug misuse. Interpretation of the DAST score should be based on the following guidelines:

DAST Score	Problem Severity
0	No Problem
1-5	Low level of problems related to drug abuse
6-10	Moderate level of problems related to drug abuse
11-15	Substantial level of problems related to drug abuse
16-20	Severe level of problems related to drug abuse

Interpretation of DAST scores is most meaningful when considered in the context of the length of time the client has been using drugs, the client's age, level of consumption, and other data collected during the ongoing assessment process.

Name:_____ Date:_____

DRUG USE QUESTIONNAIRE (DAST-20)

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question.

In the statements "drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions and (2) any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

Author: Harvey A. Skinner, Ph.D.

For information on the DAST, contact:

Dr. Harvey Skinner
Addiction Research Foundation
33 Russell Street
Toronto, Ontario, M5S 2S1
Canada

DAST - 20

#	These Questions Refer to the last 12 months	Circle Your Response	
1.	Have you used drugs other than those required for medical reasons?	YES	NO
2.	Have you abused prescription drugs?	YES	NO
3.	Do you abuse more than one drug at a time?	YES	NO
4.	Can you get through the week without using drugs?	YES	NO
5.	Are you always able to stop using drugs when you want to?	YES	NO
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	YES	NO
7.	Do you ever feel bad or guilty about your drug use?	YES	NO
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	YES	NO
9.	Has drug abuse created problems between you and your spouse or your parents?	YES	NO
10.	Have you lost friends because of your use of drugs?	YES	NO
11.	Have you neglected your family because of your use of drugs?	YES	NO
12.	Have you been in trouble at work because of drug abuse?	YES	NO
13.	Have you lost a job because of drug abuse?	YES	NO
14.	Have you gotten into fights when under the influence of drugs?	YES	NO
15.	Have you engaged in illegal activities in order to obtain drugs?	YES	NO
16.	Have you been arrested for possession of illegal drugs?	YES	NO
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	YES	NO
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc)?	YES	NO
19.	Have you gone to anyone for help for a drug problem?	YES	NO
20.	Have you been involved in a treatment program specifically related to drug use?	YES	NO

Appendix K–Ministry for Children and Families Risk Assessment, page one

BRITISH COLUMBIA

Ministry for Children and Families

COMPREHENSIVE RISK ASSESSMENT

DATE

☐ Initial ☐ Review ☐ Re-unification ☐ Case Closure

DATE: ______ PARENT(S) NAMES(S): ______

CHILD a: ______ AGE: ______ CHILD b: ______ AGE: ______

CHILD c: ______ AGE: ______ CHILD d: ______ AGE: ______

PARENTAL INFLUENCE

Note. M=Male F=Female

Summary Descriptions *(specify the applicable parent(s) and/or child(ren) to which the risk factor applies)*

P1 Abuse/Neglect of Parent

M F

- ☐ ☐ ☐ 4. Severe abuse/neglect as a child
- ☐ ☐ ☐ 3. Recurrent but not severe abuse/neglect as a child
- ☐ ☐ ☐ 2. Episodes of abuse/neglect as a child
- ☐ ☐ ☐ 1. Perceived abuse/neglect as a child with no specific incidents
- ☐ ☐ ☐ 0. No perceived abuse/neglect as a child
- ☐ ☐ ☐ 9. Insufficient information available

P2 Alcohol or Drug Use

M F

- ☐ ☐ ☐ 4. Substance use with severe social/behavioural consequences
- ☐ ☐ ☐ 3. Substance use with serious social/behavioural consequences
- ☐ ☐ ☐ 2. Occasional substance use with negative effects on behaviour
- ☐ ☐ ☐ 1. Occasional substance use
- ☐ ☐ ☐ 0. No misuse of alcohol or use of drugs
- ☐ ☐ ☐ 9. Insufficient information available

P3 Parental Expectations of Child

M F

- ☐ ☐ ☐ 4. Unrealistic expectations with violent punishment and/or neglect
- ☐ ☐ ☐ 3. Unrealistic expectations with angry conflicts and/or neglect
- ☐ ☐ ☐ 2. Inconsistent expectations leading to confusion and/or neglect
- ☐ ☐ ☐ 1. Realistic expectations with minimal support
- ☐ ☐ ☐ 0. Realistic expectations with strong support
- ☐ ☐ ☐ 9. Insufficient information available

P4 Parental Acceptance of Child

M F

- ☐ ☐ ☐ 4. Rejects and is hostile to child
- ☐ ☐ ☐ 3. Disapproves of and resents child
- ☐ ☐ ☐ 2. Indifferent and aloof to child
- ☐ ☐ ☐ 1. Usually accepting of child
- ☐ ☐ ☐ 0. Very accepting of child
- ☐ ☐ ☐ 9. Insufficient information available

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Appendix L–Ministry for Children and Families Quick Reference: Risk Factors

Quick Reference : Risk Factors

Parental Influence	Child's Influence	Family Influence	Abuse/Neglect Influence	Intervention Influence
• Abuse/Neglect of parent as a child • Alcohol or drug use • Expectations of child • Acceptance of child • Physical ability to care for child • Mental/emotional ability to care for child • Developmental ability to care for child	• Child's vulnerability • Child's response to parent • Child's behaviour • Child's mental health and development • Child's physical health and development	• Family Violence • Ability to cope with stress • Availability of social supports • Living conditions • Family identity and interactions	• Severity of abuse/neglect • Access to child by person who has abused or neglected or may abuse/neglect a child • Intent and acknowledgement of responsibility • History of abuse/neglect committed by present parents	• Parent's response to identified needs • Parents co-operation with interview

When it has been determined that a child needs protection, a child protection social worker must consider all 5 influence categories and 23 risk factors when completing the comprehensive risk assessment (Risk Decision #5) the criteria identifies likelihood of risk to a child. The social worker and others involved with the child and family then develop the Risk Reduction Service Plan to reduce the identified risk